

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED - WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
15M2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

85-188892

1. FOR STATE REGISTRAR		20. DATE KNOWN OF DEATH		21. DATE OF DEATH		22. DATE OF DEATH		23. DATE OF DEATH		24. DATE OF DEATH		
1. DECEASED NAME (TYPE OR PRINT)		2. DATE KNOWN OF DEATH		21. DATE OF DEATH		22. DATE OF DEATH		23. DATE OF DEATH		24. DATE OF DEATH		
BROOKS		C.		PALMER								
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	20. DATE KNOWN OF DEATH		21. DATE OF DEATH		22. DATE OF DEATH		
MALE	BLACK	5 14 09	76 YRS.			7 18 1985		7 18 1985		7 18 1985		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia	U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTO. COUNTY							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS							
CATONSVILLE	6003 BOOKER ROAD		FOR MOST OF WORKING LIFE		INDUSTRY							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS								
Maryland	Baltimore	Catonville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	6003 Booker Road 21228								
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS					
Belford	Minnie		230-07-0630		Ethel S. Palmer		6003 Booker Road					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS							
NO	230-07-0630		Ethel S. Palmer		6003 Booker Road							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:										YEARS		
IMMEDIATE CAUSE (a) <u>A.S.C.V.D.</u>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
(b) _____												
DUE TO, OR AS A CONSEQUENCE OF												
(c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED				
				HOUR A.M. MONTH DAY YEAR				(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
				P.M. 19								
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, FARM, ETC.)				CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED				
<u>E.P. Williamson</u>				M.D. Deputy				7/18/85				
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								
E.P. Williamson				5550 BALTO NAT'L PK 21228								
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				
BURIAL				7/22/85				Cedar Hill Cemetery Anne Arundel Co, Md.				
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
NAME ADDRESS				JUL 19 1985				<u>Davidson-Randall</u>				
Wm C March F/H Inc.				1101 E North Avenue								

80031 10

800300

80031 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					8 REG. NO. 18893				
1. DECEASED NAME (TYPE OR PRINT) JAMES G. PARKER					2a. DATE OF DEATH MONTH DAY YEAR 07 18 1985 1125AM				
3. SEX M		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 09/27/15		6. AGE (IN YEARS LAST BIRTHDAY) YRS 69		7b. HOUR 1125AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) City of Balto.		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTO 13c. CITY OR TOWN BALTO					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6207 YORK ROAD 21212		
14. FATHER'S NAME FIRST MIDDLE LAST Constantinos Parker					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII Navy					16b. SOCIAL SECURITY NO. 218-05-3655		17. INFORMANT ADDRESS Mrs. Elizabeth Parker 6207 York Rd. -21212		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY AND CARDIAC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GASTROINTESTINAL CARCINOMA</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 immediate 8 months 1 year?
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) hospital attended the deceased from <u>12 JANUARY 1985</u> to <u>17 JULY 1985</u> , that (I) (we) last saw the deceased alive on <u>17 JULY 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>J. L. Hillis M.D.</u>					DEGREE			22c. DATE SIGNED 19 JULY 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Dixon Hillis					22e. ADDRESS 3501 ST. PAUL ST. BALTO 21218				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-20-85		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller Inc-6415 Belair Rd.-21206					25a. DATE REC'D BY REGISTRAR JUL 23 1985		25b. REGISTRAR'S SIGNATURE [Signature]		

BP





206145

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF A DELAY IS NECESSARY, PLEASE  
 1. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
 2. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-1. RETAIN PAGE 5 FOR YOUR FILES.  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
 OF RECEIVING THE BODY. RECORD ON W. HESTON STREET,  
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

85 188894

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR																					
Emma		M.		Peach				7		15		1985																											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE		MONTH		DAY		YEAR																					
Female		White		10-11-06		78 YRS.		MONTHS		DAYS		HOURS		MIN.		7		16 1985																					
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				NEVER MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH																							
Maryland				U.S.A.				WIDOWED				DIVORCED				BALTO. COUNTY																							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK)				12b. KIND OF BUSINESS OR INDUSTRY																											
Woodstock				10635 Old Court Road 21163				Home maker																															
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																																							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS																							
Maryland				Woodstock				Baltimore				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				10635 Old Court Road 21163																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																													
FIRST MIDDLE LAST										FIRST MIDDLE LAST																													
James A. Peach										Josephine Oliver																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT																			
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)										220-48-9889										Mrs. Agnes Peach Norris P.O. Box 654 Leonardtown, MD. 20650																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART I DEATH WAS CAUSED BY:										PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																													
IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardiovascular Disease</u>																																							
DUE TO, OR AS A CONSEQUENCE OF																																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																																							
(b) _____																																							
DUE TO, OR AS A CONSEQUENCE OF																																							
(c) _____																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																			
																				YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																			
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										HOUR A.M. MONTH DAY YEAR																													
										P.M. 19																													
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>																				CITY OR TOWN COUNTY STATE																			
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																																							
22a. I certify that I took charge of the remains described above, held on																																							
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																																							
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																							
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																			
<i>[Signature]</i>										M.D. Deputy										7-16-85																			
EXAMINER'S NAME										ADDRESS																													
E.P. Williamson M.D.										5550 BALTONA L PK 21228																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION									
Burial										7/20/85										St. Alphonsus Cemetery										Woodstock, Baltimore, MD.									
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																			
NAME										ADDRESS																													
Loring Byers Funeral Directors, Inc.										JUL 22 1985										<i>[Signature]</i>																			
8728 Liberty Road Randallstown, Maryland 21133																																							

139 24.1 70

STANDARD TIME

139 24.1 70

A

193032

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REC'D NO. 18895

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Helen LAST PEASE			2a. DATE OF DEATH MONTH 07 DAY 06 YEAR 1985		2b. HOUR 12:30 PM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH 11 DAY 4 YEAR 27		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. CHARLES STREET 21204		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Archdiocese of Balt.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY --- 13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2939 Keswick Rd. 21211	
14. FATHER'S NAME FIRST Gordon MIDDLE Pease LAST				15. MOTHER'S MAIDEN NAME FIRST Helen MIDDLE Weatherwax LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Linelle LaBonte		ADDRESS 2939 Keswick Road Balt., Md. 21211	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HODGKIN DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION 6/22/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED upper gastrointestinal bleeding		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>06/02</u> , 19 <u>85</u> , to <u>07/06</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>07/06</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Uberoi</i>				DEGREE MD.		22c. DATE SIGNED 7/6/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. KULDIP S. UBEROI				22e. ADDRESS GBMC 6701 N. CHARLES STREET TOWSON MD 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 9, 1985		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME A. Alan Seitz Funeral Home				ADDRESS 3818 Roland Ave. Balt., Md. 21211		25a. DATE REC'D. BY REGISTRAR JUL 08 1985	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

1955  
1955

05-11-55

RECEIVED

RECEIVED



RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

214047

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8518896  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA B PEDERSEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 27 1985</b>			2b. HOUR <b>8 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN 26 1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE County</b> MD.			
10. CITY OR TOWN OF DEATH <b>DUNDALK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Heritage Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>56 Ridgemoor Rd 21221</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>FREDRICK FRECSE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kate Jones</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-54-2044</b>		17. INFORMANT			ADDRESS		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Acute Respiratory ARREST**

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dr. Peterson MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/27/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECFY) <b>Burial</b>		23b. DATE <b>7/31/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Connelly Funeral Home 300 Mace Ave. 21221</b>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>JUL 31 1985</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the condition is significant and must be noted in the

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		85 18897				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MIRIAM PERLMAN					2a. DATE OF DEATH MONTH DAY YEAR JULY 29, 1985			2b. HOUR P. 1:30 M	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 6, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MULTI MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. CITY OR TOWN BALTIMORE		13c. STREET ADDRESS / ZIP CODE 6807 PARK HTS. AVE. #21215		
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN BLOCH					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA MANKO				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-30-2359		17. INFORMANT BENNARD PERLMAN 6603 BAYTHORNE RD. BALTO., MD 21209					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ovarian Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Nov 21, 1975 to July 29, 1985, that (I) (we) lost saw the deceased alive on July 20, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Daniel Bakal				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED July 29, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL BAKAL, M.D.				22e. ADDRESS 600 REISTERSTOWN RD BALTO., MD 21208					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 31, 1985		23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR AUG 2 1985		25b. REGISTRAR'S SIGNATURE Jana Anderson-Henderson			

020815



PODOLCO DI FIBER  
D'ITALIA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 18898

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST <i>Helen R. Petro</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>7-10-85</i>		2b. HOUR MIN. <i>10:40</i> M	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>4-4-10</i>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>75</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. County</i> MD.		
10. CITY OR TOWN OF DEATH <i>Balto. Md. 21228</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Meridian Nreg. Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Supervisor</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Koppers</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <i>3909 6th Street 21225</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Heeter</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>174-16-8590</i>		17. INFORMANT ADDRESS <i>Donna Fonte 4108 Doris Ave Balto Md 21225</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>COPD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Heart</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>A. Chatterjee</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. CHATTERJEE</i>		22e. ADDRESS <i>3827 Annapolis Road</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>7/13/85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem Pk</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Howard Md</i>
24. FUNERAL DIRECTOR <i>George J. Gonce 4001 Ritchie Hwy Balto Md</i>			25a. DATE REC'D. BY REGISTRAR (b). REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i> <b>JUL 12 1985</b>		

MEDICAL CERTIFICATION

BP

10-10-10

10-10-10

XX

10-10-10

10-10-10

XX

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10



10-10-10

10-10-10

203235

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 18899

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph Louis Placht		2a. DATE OF DEATH MONTH DAY YEAR 7/13/85		2b. HOUR 45 P.M.	
3. SEX Male		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 7 19 04		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vice President		12b. KIND OF BUSINESS OR INDUSTRY U.S.F.&G.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph A. Placht		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Baehr		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 215-07-8552		17. INFORMANT ADDRESS Mrs. Anne P. Lyons 1601 Templeton Rd. Towson, Md. 21204		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PROSTATIC CANCER WITH METASTASIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>7/7</u> , 19 <u>85</u> , to <u>7/13</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>7/13</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>K R Faulkner MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/13/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kendall R. Faulkner, M.D.		22e. ADDRESS Stella Maris Hospice 2300 Dulany Valley Rd.-Towson, MD 21204					
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE July 16, 1985		23c. NAME OF CEMETERY OR CREMATORY Dulany Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium, Balto. Co., Md.	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212		ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR JUL 18 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove completed pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, there's any injury, or other traumatic event, the medical examiner must be notified to view.

38000



CHILLY  
M  
SECOND

NOV  
COTTON  
FIELD

IN O. 1911

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 85 18900

1. DECEASED NAME (TYPE OR PRINT) <b>(1) RUBEN</b>		FIRST (REUBEN) MIDDLE <b>PLEASANT</b>		LAST <b>PLEASANT</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>July 1, 1985</b>		2b. HOUR <b>1:20 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11, 1 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTIMORE MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ruben Pleasant</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Green</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>419-07-6127</b>		17. INFORMANT ADDRESS <b>Gladys Pleasant 2403 Shirley Avenue</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive pulmonary embolism</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>June 22</b> , 19 <b>85</b> , to <b>July 1</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>July 1</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Rudiger Breiteneker</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>July 2, 1985</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rudiger Breiteneker, M.D.</b>				22e. ADDRESS <b>6701 N. Charles St. Balto. MD 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/8/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>		23d. LOCATION CITY OR TOWN <b>Randallstown,</b>		STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>William C. March F/H</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 09 1985</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Fordella</i>	

108125



THE EXAMINER

COLLIER & FERR

REG. NO. 8-9 D

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		21. MONTH		22. DAY		23. YEAR		24. HOUR	
Bennett		LEE		(B)		POPE SR		20. DATE KNOWN OF DEATH		21. MONTH		22. DAY		23. YEAR		24. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		25. DATE		26. MONTH		27. DAY	
MALE		BLACK		09 11 30		54 YRS.		MONTHS		DAYS		HOURS		MIN.		25. DATE	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BALTIMORE CITY		11. BALTIMORE COUNTY		12. BALTIMORE CITY		13. BALTIMORE COUNTY	
N.C.		USA		WIDOWED		X		BALTIMORE CITY		BALTIMORE CITY		BALTIMORE COUNTY		BALTIMORE CITY		BALTIMORE COUNTY	
14. CITY OR TOWN OF DEATH		15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		17. KIND OF BUSINESS OR INDUSTRY		18. CITY OR TOWN OF DEATH		19. BALTIMORE CITY		20. BALTIMORE COUNTY		21. BALTIMORE CITY		22. BALTIMORE COUNTY	
TOWSON		ST JOSEPH HOSPITAL		16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		17. KIND OF BUSINESS OR INDUSTRY		18. CITY OR TOWN OF DEATH		19. BALTIMORE CITY		20. BALTIMORE COUNTY		21. BALTIMORE CITY		22. BALTIMORE COUNTY	
18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		19a. STATE		19b. COUNTY		19c. CITY OR TOWN		19d. INSIDE CITY LIMITS?		19e. STREET ADDRESS		19f. CITY		19g. STATE		19h. ZIP CODE	
MD		BALTIMORE		BALTIMORE		BALTIMORE		YES		1226 N. Broadway		21213		21213		21213	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. SOCIAL SECURITY NO.		18. INFORMANT		19. ADDRESS		20. CITY		21. STATE		22. ZIP CODE	
Norman		Ella		Yes		242-42-5680		Ella M. Pope		1226 N. Broadway		21213		21213		21213	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. SOCIAL SECURITY NO.		18. INFORMANT		19. ADDRESS		20. CITY		21. STATE		22. ZIP CODE	
Norman		Ella		Yes		242-42-5680		Ella M. Pope		1226 N. Broadway		21213		21213		21213	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		20. CAUSE OF DEATH		21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		22. CAUSE OF DEATH		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		24. CAUSE OF DEATH		25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		26. CAUSE OF DEATH	
PART I: DEATH WAS CAUSED BY:		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden	
IMMEDIATE CAUSE (a)		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden	
DUE TO, OR AS A CONSEQUENCE OF		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden	
(b)		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden	
DUE TO, OR AS A CONSEQUENCE OF		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden	
(c)		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden		Sudden	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		21. YES		22. NO		23. YES		24. NO		25. YES		26. NO	
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. EXTERNAL CAUSE WAS		21e. TIME OF INJURY		21f. HOW INJURY OCCURRED		21g. EXTERNAL CAUSE WAS		21h. TIME OF INJURY		21i. HOW INJURY OCCURRED	
UNDERLYING		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2		UNDERLYING		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2		UNDERLYING		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2	
CONTRIBUTING		P.M.		21f. LOCATION		CONTRIBUTING		P.M.		21g. LOCATION		CONTRIBUTING		P.M.		21h. LOCATION	
CAUSE OF DEATH		19		STREET		CAUSE OF DEATH		19		CITY OR TOWN		CAUSE OF DEATH		19		CITY OR TOWN	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21h. LOCATION		21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21j. LOCATION		21k. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21l. LOCATION	
WHILE AT WORK		STREET, FACTORY, FARM, ETC.)		STREET		WHILE AT WORK											

**MEDICAL CERTIFICATION**

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. RETAIN PAGE 3 FOR YOUR FILES.  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 501 W. PENNSYLVANIA STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76



10:00

10:00

10:00

10:00

10:00

10:00

10:00



214149

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**1- FOR  
STATE  
REGISTRAR**

REG. NO. 8902

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Marvin</b>			MIDDLE <b>L.</b>			LAST <b>Porter, Sr.</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>July 22 1985</b>			2b. HOUR <b>7:20 PM</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 11 1937</b>	6. AGE IN YEARS (LAST BIRTHDAY) <b>48</b> YRS.	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>		7c. DATE PRONOUNCED DEAD <b>July 22 1985</b>			7d. HOUR <b>7:20 PM</b>						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>			MD.					
10. CITY OR TOWN OF DEATH <b>Rossville</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman-Tandam Mill</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>					
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>7605 Babikow Rd. 21237</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry F. Porter, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evelyn T. Hellman</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-34-6441</b>			17. INFORMANT ADDRESS <b>Jeanne E. Porter 7605 Babikow Rd. 21237</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordem Arrest from</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Acute Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden 35 yrs</b>
--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D. TITLE (SPECIFY) <u>Deputy</u>		DATE SIGNED <u>7/22/85</u>
EXAMINER'S NAME (TYPE OR PRINT) <b>Charles F. O'Donnell</b>		ADDRESS <b>7501 York Rd. Towson, Md. 21204</b>

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>7-25-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME <b>LASSAHN Funeral Home</b>		ADDRESS <b>7401 Belmar</b>	25a. DATE REC'D. BY REGISTRAR <b>28 1985</b>
		25b. REGISTRAR'S SIGNATURE <u>Julia Tindall</u>	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DM-3. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 7/76

24

Handwritten notes and signatures, including a large signature at the bottom right.

217063

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. WITH PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT RECORD. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8903

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

Cynthia M. Powers  
CYNTHIA M. POWERS

2a. DATE KNOWN  
OF  
ESTI-  
MATED

7/28 1985  
MONTH DAY YEAR

2b. HOUR  
19.25  
P. M.

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

8 24 60

6. AGE (IN YEARS  
LAST BIRTHDAY)

24 YRS.

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.

MONTHS DAYS HOURS MIN.

2c. DATE  
PRONOUNCED  
DEAD

7/29/85 1985

2d. HOUR  
1.00  
P. M.7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County

MD.

10. CITY OR TOWN OF DEATH

Fort Howard

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

9123 Todd Ave. 21052

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS  
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. CITY OR TOWN

Baltimore

13c. CITY OR TOWN

Ft. Howard

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

9123 Todd Ave. 21052

14. FATHER'S NAME

Alonzo

MIDDLE

M.

LAST

Dillian Sr.

15. MOTHER'S MAIDEN NAME

Margaret

MIDDLE

M.

LAST

Diven

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

217-82-8667

17. INFORMANT

Dennis H. Powers 9123 Todd Ave.

ADDRESS: Ft. Howard, MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Carcinoma of Cervix with  
generalized metastases.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opiniondeath resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.ACTUAL  
SIGNATURE

Kathleen

TITLE (SPECIFY)

M.D. Deputy

MEDICAL EXAMINER

DATE  
SIGNED

7/29/85

EXAMINER'S NAME  
(TYPE OR PRINT)

K.S. AHLUWALIA

ADDRESS

2112 Dundalk Av Balt. 21222

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

8/1/85

23c. NAME OF CEMETERY OR CREMATORY

Crestlawn

23d. LOCATION  
CITY OR TOWN

Sykesville Howard Md

24. FUNERAL DIRECTOR

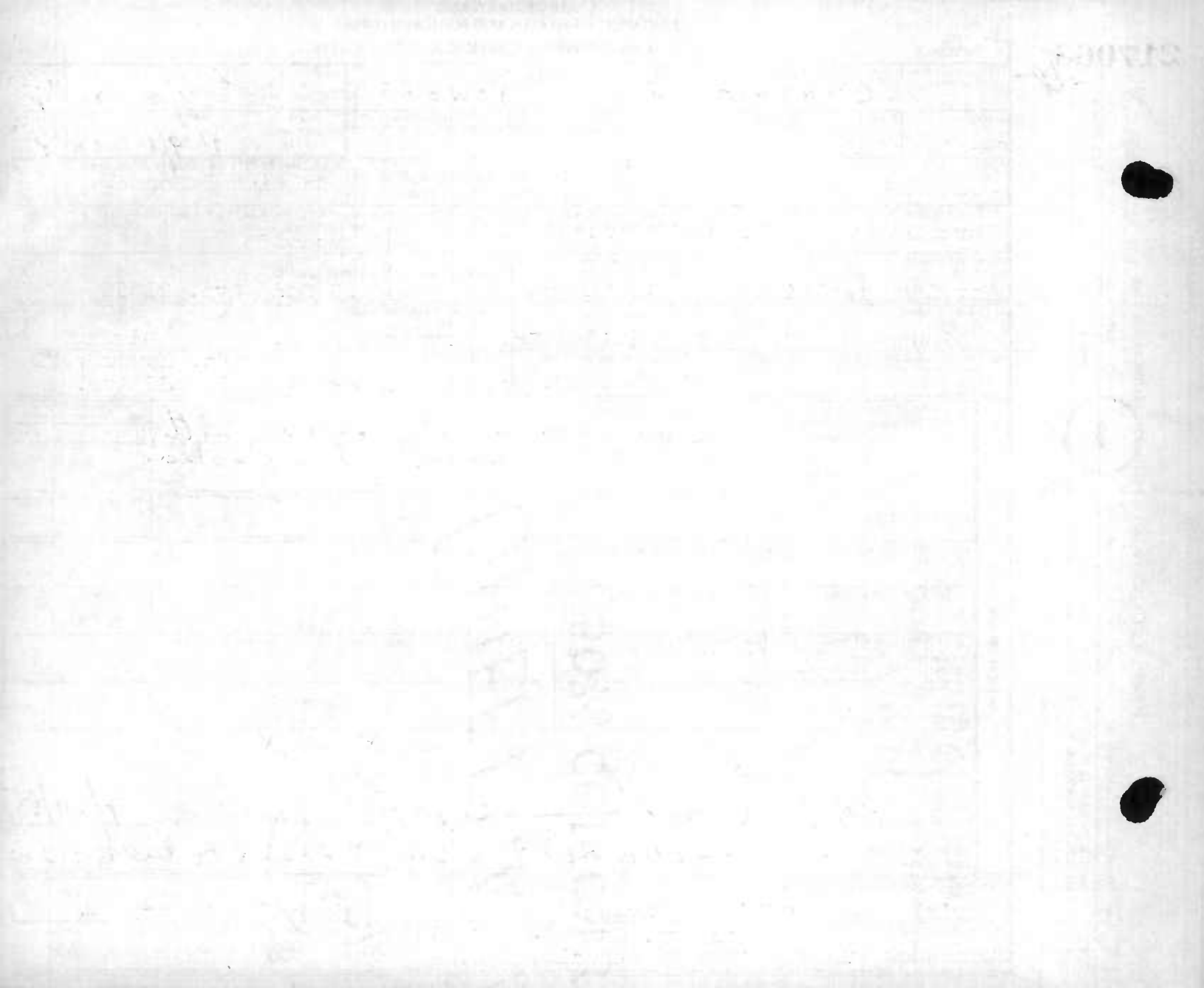
NAME 7922 Wise Ave. Dundalk, MD  
ADDRESS Duda-Ruck Funeral Home of Dundalk, Inc.

24. RECEIVED BY REGISTRAR

21222 AUG 1 1985

25b. REGISTRAR'S SIGNATURE

John Davidson Dundalk



150111

30

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8904	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DORIS G. PRICE</b>										2. DATE KNOWN OF DEATH MONTH DAY YEAR <b>7/7 1985</b>	2b. HOUR <b>10 45 A.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 21, 1919 66 YRS.</b>	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>66 YRS.</b>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. <b>66 YRS.</b>	7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. <b>66 YRS.</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7/7 1985</b>	2d. HOUR <b>10 45 A.M.</b>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>404 Oak Forest</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>404 Oak Forest 21228</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Goldstone</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fay Younkins</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   IF YES, GIVE WAR OR DATES <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-05-6720</b>		17. INFORMANT <b>Robert S. Price</b>		ADDRESS <b>Same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanotic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Stanley Z. Felsberg</i>		TITLE (SPECIFY) <b>M.D.</b>		MEDICAL EXAMINER <b>DR. PRICE</b>		DATE SIGNED <b>7/7/85</b>		Suite 8A			
EXAMINER'S NAME (TYPE OR PRINT) <b>Stanley Z. Felsberg M.D.</b>		ADDRESS <b>11 E. Chase Street, Baltimore, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7/8/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Md.</b>					
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witke Funeral Homes P.A.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 08 1985</b>		25b. REGISTRAR'S SIGNATURE <i>Stanley Z. Felsberg</i>			

100000  
100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85-18903

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Mrs. Vera Anna Pritchett								July 8 1985				0223 M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Female		Caucasian		July 12 1918		66		YRS.		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		USA				Baltimore County MD											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Randallstown		Baltimore County General Hospital				Homemaker											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE									
Maryland		Baltimore		Randallstown				3716 Brice Run Rd. Apt C. 21133									
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
Harry Labatt Payne						Anna Catherine Bosman Holden											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.				17. INFORMATION FOR MODERN				21207			
No						219-05-567				Mr. Emory F. Pritchett Jr. 2026 N. Rolling Rd. Baltimore Maryland							

<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c). <b>PART 1. DEATH WAS CAUSED BY.</b> IMMEDIATE CAUSE (a) <u>Cardiac Azytote</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypotension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>S/P cardiopulmonary Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
<b>PART 2. OTHER SIGNIFICANT CONDITIONS</b> CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>C.O.P.D., # (R) Humerus non-displaced, P. <del>clavicle</del> clavicle inf</u>			
<b>19a. DATE OF OPERATION</b> <u>5/19/1985</u>	<b>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>laceration (R) leg.</u>	<b>20a. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>	<b>21b. TIME OF INJURY</b> HOUR A.M. MONTH DAY YEAR P.M. 19	<b>21c. HOW INJURY OCCURRED</b> (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
<b>21d. INJURY OCCURRED</b> WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	<b>21e. PLACE OF INJURY</b> (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	<b>21f. LOCATION</b> CITY OR TOWN COUNTY STATE	
<b>22a. I certify that (I) (this hospital) attended the deceased from</b> _____, 19____, <b>to</b> _____, 19____, <b>that (I) (we) last saw the deceased alive on</b> _____, 19____, <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</b>			
<b>22b. SIGNATURE</b> <u>Hafeez A Syed</u>		<b>22c. DATE SIGNED</b> <u>7/8/85</u>	
<b>22d. PHYSICIAN'S NAME</b> (TYPE OR PRINT) <u>HAFFEEZ A SYED</u>		<b>22e. ADDRESS</b> <u>BALTIMORE COUNTY GEN HOSPITAL</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> <small>(SPECIFY)</small> <u>Burial</u>	<b>23b. DATE</b> <u>7-10-85</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Glen Haven Memorial Pk.</u>	<b>23d. LOCATION</b> CITY OR TOWN COUNTY STATE <u>Glen Burnie A. A. Maryland</u>
<b>24. FUNERAL DIRECTOR</b> <u>Loring Byers Funeral Directors, Inc.</u> <u>8728 Liberty Road Randallstown, Maryland 21133</u>		<b>25a. DATE REC'D. BY REGISTRAR</b> <u>JUL 09 1985</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL ON ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Please remove carbon papers. Pages 1 and 2 should be retained and within 72 hours after de

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP\_\_\_\_\_

13001

3



Handwritten notes and markings on the right side of the page, including a large '14' and various scribbles.

Yours Anna

Constance

My dear

My dear

My dear

My dear

My dear

My dear

My dear

My dear

My dear

My dear

My dear

My dear

My dear



BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. It should be detached for use as the burial-transit permit. Then please remove carbon for parts 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

200095

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 5 1 8 9 0 6 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN M RAINES, SR.					2a. DATE OF DEATH MONTH DAY YEAR 7/13/85			2b. HOUR 2:00 P	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN 2, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 814 MOCKINGBIRD LANE #102				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY UTILITY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN 21204					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21204 814 MOCKINGBIRD LANE #102		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN M. RAINES					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA ALICE McKEE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS 21204 ANNA J. RAINES 814 MOCKINGBIRD LANE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory &amp; cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of lungs with diffused metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2+ Years</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Gradual</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>10</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 5, 1981</u> to <u>July 13, 1985</u> that (I) (x) last saw the deceased alive on <u>June 15, '85</u> and that in (my) (xx) opinion death occurred on the date and hour and from the causes stated above, (I) (x) (did) (did not) view the body after death.									
22b. SIGNATURE <u>S. J. Liu M.D.</u> DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/13/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. J. LIU, M. D.					22e. ADDRESS 1900 E. Northern Parkway Balto, MD 21239				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE JULY 15, '85		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 15 1985 <u>J. H. Hurdell</u>				

• 47 •

281015

9:00:31

xx x

22

25 July

20/11/15

2. 4. 1. 2.

228001

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 8518907							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLOTTE V. RAMSBURG				2a. DATE OF DEATH MONTH DAY YEAR 07 03 85				2b. HOUR MIN. 4:45 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 19 01		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDIAN NURSING CENTER CATONSVILLE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY CARROLL		13c. CITY OR TOWN SYKESVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7255 Woodbine Rd. 21784	
14. FATHER'S NAME FIRST MIDDLE LAST George Lawson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OLIVIA Baublitz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-10-1536		17. INFORMANT ADDRESS Mrs. BLANCHE V. WRIGHT BALTO. MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD, myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral vascular insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/30/82 to 7/1, 1985, that (I) (we) lost saw the deceased alive on 7/1, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. John Shaw				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/6/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John Shaw				22e. ADDRESS 3616 Horned Owl Ct. Ellicott City Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUL 6, 85		23c. NAME OF CEMETERY OR CREMATORY ALL SAINTS GEN.		23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN, MD.			
24. FUNERAL DIRECTOR NAME ELINE FUNERAL HOME				24. FUNERAL DIRECTOR ADDRESS REISTERSTOWN, MD.		25a. DATE REC'D BY REGISTRAR JUL 10 1985			

BP.

DHMH - 16 50M 4/83  
(VRA 15, 4)

222001

V.

HOUSEWIFE

SYKESVILLE

CARROLL

OLIVIA

MRS. BLANCHE V. WRIGHT BALTO. MD.

NO

BURIAL JUL 6, 85 ALL SAINTS CEM. REISTERSTOWN, MD.

ELINE FUNERAL HOME REISTERSTOWN, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. Page 19 should be retained by the funeral director. Page 20 should be retained by the funeral director. Page 21 should be retained by the funeral director. Page 22 should be retained by the funeral director. Page 23 should be retained by the funeral director. Page 24 should be retained by the funeral director. Page 25 should be retained by the funeral director. Page 26 should be retained by the funeral director. Page 27 should be retained by the funeral director. Page 28 should be retained by the funeral director. Page 29 should be retained by the funeral director. Page 30 should be retained by the funeral director. Page 31 should be retained by the funeral director. Page 32 should be retained by the funeral director. Page 33 should be retained by the funeral director. Page 34 should be retained by the funeral director. Page 35 should be retained by the funeral director. Page 36 should be retained by the funeral director. Page 37 should be retained by the funeral director. Page 38 should be retained by the funeral director. Page 39 should be retained by the funeral director. Page 40 should be retained by the funeral director. Page 41 should be retained by the funeral director. Page 42 should be retained by the funeral director. Page 43 should be retained by the funeral director. Page 44 should be retained by the funeral director. Page 45 should be retained by the funeral director. Page 46 should be retained by the funeral director. Page 47 should be retained by the funeral director. Page 48 should be retained by the funeral director. Page 49 should be retained by the funeral director. Page 50 should be retained by the funeral director. Page 51 should be retained by the funeral director. Page 52 should be retained by the funeral director. Page 53 should be retained by the funeral director. Page 54 should be retained by the funeral director. Page 55 should be retained by the funeral director. Page 56 should be retained by the funeral director. Page 57 should be retained by the funeral director. Page 58 should be retained by the funeral director. Page 59 should be retained by the funeral director. Page 60 should be retained by the funeral director. Page 61 should be retained by the funeral director. Page 62 should be retained by the funeral director. Page 63 should be retained by the funeral director. Page 64 should be retained by the funeral director. Page 65 should be retained by the funeral director. Page 66 should be retained by the funeral director. Page 67 should be retained by the funeral director. Page 68 should be retained by the funeral director. Page 69 should be retained by the funeral director. Page 70 should be retained by the funeral director. Page 71 should be retained by the funeral director. Page 72 should be retained by the funeral director. Page 73 should be retained by the funeral director. Page 74 should be retained by the funeral director. Page 75 should be retained by the funeral director. Page 76 should be retained by the funeral director. Page 77 should be retained by the funeral director. Page 78 should be retained by the funeral director. Page 79 should be retained by the funeral director. Page 80 should be retained by the funeral director. Page 81 should be retained by the funeral director. Page 82 should be retained by the funeral director. Page 83 should be retained by the funeral director. Page 84 should be retained by the funeral director. Page 85 should be retained by the funeral director. Page 86 should be retained by the funeral director. Page 87 should be retained by the funeral director. Page 88 should be retained by the funeral director. Page 89 should be retained by the funeral director. Page 90 should be retained by the funeral director. Page 91 should be retained by the funeral director. Page 92 should be retained by the funeral director. Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 9 0 8  
REG. NO.FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Helen N. Rath			2a. DATE OF DEATH MONTH DAY YEAR 7 8 85			2b. HOUR 10:25AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 4 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 223 Regester Ave. 21212				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Food Service		
12b. KIND OF BUSINESS OR INDUSTRY Hutzlers								
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 223 Regester Ave. 21212								
14. FATHER'S NAME FIRST MIDDLE LAST Louis Niedrach				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Distelhurst				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-34-4653		17. INFORMANT ADDRESS Eleanor R. Mann 1807 Thornton Rd. 21204				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic breast cancer.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>5</u> 19 <u>85</u> to <u>7/8</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7/8</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Alan L Kimmel MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>7/9/85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kimmel</u>				22e. ADDRESS <u>222 W Cold Spring La</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>7/9/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Md.</u>		
24. FUNERAL DIRECTOR NAME <u>Mitchell-Wiedefeld Home</u>				25a. DATE REC'D. BY REGISTRAR <u>JUL 9 1985</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		
ADDRESS <u>6500 York Rd.</u>								

232

197

197

197

197

197

197

197

197

197

197

197

197

197

197

197

197

197

197

197

197

197

214062

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 9 0 9  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROSE MARY REDMAN		2a. DATE OF DEATH MONTH DAY YEAR 07 29 '85		2b. HOUR 1:40P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 6, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Cockeysville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Apt. D 303 Limestone Valley Dr. 21030
14. FATHER'S NAME FIRST MIDDLE LAST Leonard		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Albina Abriola		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 143-07-9027		17. INFORMANT ADDRESS Grace S. Lancelotta -5241 Frederick Ave. 21229

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC DEBILITATION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ESOPHAGEAL CARCINOMA</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>POOR NUTRITION, CONGESTIVE HEART FAILURE</u>				
19a. DATE OF OPERATION 7/26/85	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PT REFUSED ALL P.O. INTAKE	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7/21 85, to 7/29 85, that (I) (we) last saw the deceased alive on 7/29 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Joy L. Howard, M.D.		22c. DATE SIGNED 7/29/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOY L. HOWARD, M.D.		22e. ADDRESS GBMC - 6701 N. CHARLES ST		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-2-85	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto. Md.	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR JUL 31 1985	25b. REGISTRAR'S SIGNATURE John Davidson-Rendall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ST40ES





207059

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 9 1 0  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Lillian Gloria Reich			2a. DATE OF DEATH MONTH DAY YEAR July 19, 1985			2b. HOUR 1:45 P.M.				
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12-07-1906		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3626 Forest Hill Road 21207				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Lochearn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3626 Forest Hill Road 21207	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Holmes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa Stapf						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-07-8739A		17 INFORMANT Mrs. Gail Leon ADDRESS 3334 Halter Road Westminster, MD, 21157						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of sigmoid colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Nov. 1982</u> <u>Nov. 1982</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION <u>Nov. 1982</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>resection of carcinoma of colon</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) <u>Marvin Goldstein</u> attended the deceased from <u>July 1, 1985</u> to <u>July 19, 1985</u> , that (I) (we) saw the deceased alive on <u>July 6, 1985</u> , and that in (my) <u>my</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> sign the body after death.										
22b. SIGNATURE <u>Marvin Goldstein</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED <u>July 19, 1985</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Marvin Goldstein				22e. ADDRESS 6001 Park Heights Avenue						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7/20/85		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. M D.				
24 FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD. 21133						25a. DATE REC'D. BY REGISTRAR JUL 22 1985		25b. REGISTRAR'S SIGNATURE <u>Gail Davidson-Randall</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

BP



20% 100%



Handwritten text, possibly a signature or a note, located below the circular stamp.



Handwritten text, possibly a signature or a note, located below the small diagram.



Handwritten text, possibly a signature or a note, located below the small diagram.



Handwritten text, possibly a signature or a note, located below the small diagram.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified and a report filed.

203126

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8518911 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA RESNICK						2a. DATE OF DEATH MONTH DAY YEAR JULY 4, 1985			2b. HOUR 4:50P.M.		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 24, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WHOLESALE		12b. KIND OF BUSINESS OR INDUSTRY POULTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE						13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6510 PARK HEIGHTS AVE., (21215)	
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM GOLDSTEIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GOLDIE UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-30-4869		17. INFORMANT ADDRESS MR. EDWIN LEVY 3701 OLD COURT RD. 21208							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>AS LVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 yr +</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hr</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u>											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION <u>none</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>none</u> (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>none</u> 19 <u>85</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>none</u>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/4</u> 19 <u>85</u> to <u>7/4</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7/4</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. Maurice Feldman</u>						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/5/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MAURICE FELDMAN						22e. ADDRESS 6610 CROSS COUNTRY BLVD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 7/5/85		23c. NAME OF CEMETERY OR CREMATORY SHAAREI ZION CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR'S NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215											

JUL 10 1985



199035

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 9 1 2  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN VIOLA RICE			2a. DATE OF DEATH MONTH DAY YEAR JULY 9, 1985		2b. HOUR 3:20 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 12, 1900		
6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 301 N. Charles St. Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
12b. KIND OF BUSINESS OR INDUSTRY		12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Towson 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 301 N. Charles St. Ave. 21204				
14. FATHER'S NAME FIRST MIDDLE LAST John Edward Preston			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Agnes Brown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-09-9020B		17. INFORMANT Byron E. Rice		
17. ADDRESS Same		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 1 day DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis 10 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) Parkinson's Disease - 10 yrs.				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK NOT WHERE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 3/13, 1985, to 7/9, 1985, that (I) saw the deceased alive on 4/12, 1985, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death.				
22b. SIGNATURE Norman R. Freeman, M.D.		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22e. ADDRESS 4300 N. Charles St. Baltimore, Md. 21218		22f. DATE SIGNED 7/11/85				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 12, 1985		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto. Co., Md.		24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto., Md. 21212				
25a. DATE REC'D. BY REGISTRAR JUL 12 1985		25b. REGISTRAR'S SIGNATURE Sue Davidson-Randall				

BP



191148

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

REG. NO.

1 8 9 1 3

1. DECEASED NAME (TYPE OR PRINT) Thomas D. Rich			2a. DATE OF DEATH MONTH DAY YEAR July 4, 1985		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 12, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
10. CITY OR TOWN OF DEATH Parkville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perring Pkwy Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - Banker	12b. KIND OF BUSINESS OR INDUSTRY Banking	
13a. STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Millersville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 334 Locust Thorn Court 21108	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas W. Rich		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Rea			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 408-28-3081		17. INFORMANT ADDRESS John T. Rich Same as #13.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pulmonary Embolism

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

- 1/2 hour

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

Deep venous thrombosis

- ?

DUE TO, OR AS A CONSEQUENCE OF

(c)

Red blood cell

years.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Imposter Brain Tumor 14 years

19a. DATE OF OPERATION NA	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA	21f. LOCATION STREET CITY OR TOWN COUNTY STATE NA	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Adolfo L. Lopez	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7/5/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adolfo L. Lopez, M.D.		22e. ADDRESS 109 Ruxton Towers Towson, Md. 21204	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 8, 1985	23c. NAME OF CEMETERY OR CREMATORY Lafayette Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Lafayette Georgia
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, md. 21204		25a. DATE REC'D. BY REGISTRAR JUL 07 1985	25b. REGISTRAR'S SIGNATURE R. Anderson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP



5070

உதாரணம்:

(b) (7)(C), (b) (7)(D)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 9 1 4  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) <b>XEXTER</b>		FIRST <b>ROBERSON</b>		MONTH <b>7</b> DAY <b>27</b> YEAR <b>85</b>	
3 SEX <b>MALE</b>		4 RACE <b>CAUCASION</b>		5. DATE OF BIRTH	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS	
10 CITY OR TOWN OF DEATH <b>Middle River</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>IVY HALL NSQ. HOME</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD.</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>Middle River</b>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BALTO. CO.</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>400-14-9563</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ed.</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Assault Cerebral Key Arter.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Smoking. Parkinson's disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Dementia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>a</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>T. A. Grow</b>		DEGREE		22c. DATE SIGNED <b>7-28-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>T. A. Grow</b>		22e. ADDRESS <b>223 E. Blvd BALTO MD 21221</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>		23b. DATE <b>7/27/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROBERSON CEMETERY</b>	
24. FUNERAL DIRECTOR NAME <b>CONNELLY FUNERAL HOME</b>		ADDRESS <b>300 MACE AVE</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 31 1985</b>	
				25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

BP

2000

198123

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 1 5  
REG. NO.

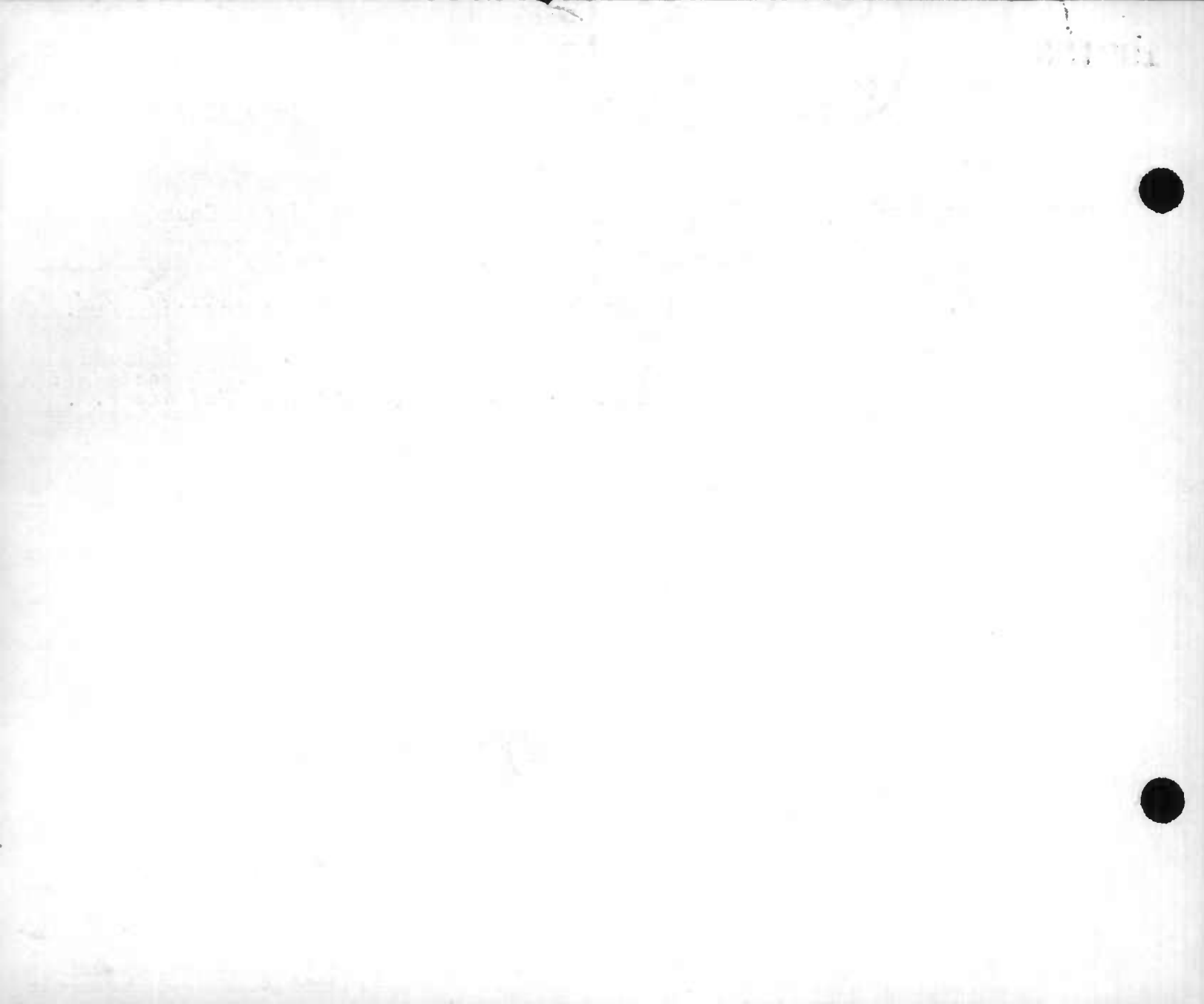
1. DECEASED NAME (TYPE OR PRINT) Mina Robinson		2a. DATE OF DEATH MONTH DAY YEAR July 12 1985		2b. HOUR 9:15 M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 16 1894		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County Gen.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Lutherville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Anderson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah V. Hoshall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-32-8891		17. INFORMANT ADDRESS Lester N. Robinson Heights P.K.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) pneumonia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. certify that (I) (this hospital) attended the deceased from 7/10 19 85, to 7/12 19 85, that (I) (we) last saw the deceased alive on 7/12 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Boston		DEGREE MD		22c. DATE SIGNED 7/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J Boston MD		22e. ADDRESS Baltimore County Gen Hosp.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-15-1985		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial	
24. FUNERAL DIRECTOR NAME Eline Funeral Home		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll Md.		25a. DATE REC'D. BY REGISTRAR JUL 15 1985	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completely. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP



212146

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 9 1 6  
REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>FRANK JOSEPH ROHE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 27 1985</b>		2b. HOUR M
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 15 1903</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>600 MEYERS RD</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRANSIT ANALYST</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>BALTO CITY</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>BALTO</b> 13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>600 MEYERS RD. 21228</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>LEO E ROHE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BARBARA C. RIPPLE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>ARMY</b>		16b. SOCIAL SECURITY NO. <b>213-05-9608</b>		17. INFORMANT ADDRESS <b>BARBARA DIEHL INGLESIDE AVE 1507</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bone Marrow Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple Myeloma</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 mo</b> <b>2 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/19</b> 19 <b>83</b> , to <b>7/27</b> 19 <b>85</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>7/24</b> 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) <input checked="" type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <b>William C Waterfield</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/29/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William C Waterfield</b>		22e. ADDRESS <b>St Agnes Hospital 900 Caton Ave Balt 21229</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>7/31/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD</b>	23e. DATE REC'D. BY REGISTRAR <b>JUL 29 1985</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>WEBER FUNERAL HOME 12 PM MONISTON AVE 5311</b>		25. REGISTRAR'S SIGNATURE <b>Davidson-Rendall</b>			

BP \_\_\_\_\_



198058

Film G606 item 10, 13b, 13c  
 1. FOR STATE REGISTRAR 8/21/85 rja  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

85 REG. NO. 18917

1. DECEASED NAME (TYPE OR PRINT) <b>Robert Hubbard Rook</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 13 1985</b>			2b. HOUR M <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 18 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baldwin</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Box 418 2300 Baldwin Mill Rd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Exec. Pres.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Chemical</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baldwin</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2300 Baldwin Mill Rd., 21047</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Russell Rook</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Hubbard</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WW II</b>			17. INFORMANT ADDRESS <b>Box 418</b>			
			<b>357-16-3827</b>			<b>Norma J. Rook, 2300 Baldwin Mill Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC CDMA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>METASTATIC LIVER DUEAE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PANCREATIC CARCINOMA.</b>						21047 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION <b>NA</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>NA</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>NA</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>January 16, 1985</b> to <b>July 17, 1985</b> , that (I) (we) last saw the deceased alive on <b>July 12, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Adolfo L. Lopez</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/15/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Adolfo L. Lopez, M.D.</b>						22e. ADDRESS <b>109 Ruxton Towers, Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>7/15/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto. Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>J. E. Lowell Lemmon, 10 W. Padonia Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 15 1985</b>			
						25b. REGISTRAR'S SIGNATURE <i>John A. ...</i>			





213033

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 1 8  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) STEPHANIE HELEN ROY			2a. DATE OF DEATH MONTH DAY YEAR 7-20-85			2b. HOUR 1:45 P.M.			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 12 29 1923		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CO. MD.			
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL HOSP. HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
13a. STATE MARYLAND			13b. COUNTY CARROLL		13c. CITY OR TOWN PINKSBURG		13d. STREET ADDRESS / ZIP CODE 1612 WALTER AVE 21048		
14. FATHER'S NAME KAROL MAZAK				15. MOTHER'S MAIDEN NAME MAGALENA BOLEGA					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 144-16-3054		17. INFORMANT ADDRESS ROBERT ROY SR. 1612 WALTER AVE 21048				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>DIABETES MELLITUS; SEVERE PERIPHERAL VASCULAR DISEASE</u>									
19a. DATE OF OPERATION 7-17-85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BILATERAL SUPERFICIAL FEMORAL ARTERIES OBSTRUCTION			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		21g. CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7-16</u> 19 <u>85</u> to <u>7-20</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>7-20</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Giuseppe</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 7-20-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ORLANDO B. CONNAN, M.D.					22e. ADDRESS 6064 - RANDALLSTOWN MD. 21133				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JULY 24, 1985		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN MEM. GARDENS		23d. LOCATION CITY OR TOWN PINKSBURG CARROLL MD.		
24. FUNERAL DIRECTOR Robert A. Meyer 91 Willis St. 21157					25a. DATE REC'D. BY REGISTRAR JUL 25 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendall		

[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

2280021

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH85  
REG. NO.

18919

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Julia RUSINKO			MONTH DAY YEAR July 20, 1985			11:55p M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE			7. IF UNDER 1 YEAR		
Female	White	MONTH DAY YEAR Oct. 8, 1894	90 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Hungary	U.S.A.		Baltimore County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Rosedale	Franklin Square Hosp.			Housewife			Own Home	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Baltimore			Rosedale		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13d. STREET ADDRESS / ZIP CODE		
FIRST MIDDLE LAST N/A			FIRST MIDDLE LAST N/A			6600 Ridge Rd. 21237		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMED BY		
No			169-07-0404-D			(Grandson) 3800 Clarks Point Rd. Ishmael Toth Balto., Md. 21220		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Shock</u> (b) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF <u>Atrial Flutter-Fibrillation</u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (this hospital) attended the deceased from <u>July 20, 1985</u> to <u>July 20, 1985</u> , that (we) last saw the deceased alive on <u>July 20, 1985</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Roger Moushabek M.D.</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED <u>7/20/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
Roger Moushabek, M.D.			9000 Franklin Square Drive, 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			7/24/85		Oak Grove Cem.		Morgantown Monongalia W.Va.	
24. FUNERAL DIRECTOR			25a. DATE RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Barnes Fleming Funeral Service			21018 Benson, Md.			JUL 26 1985		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

100% COTTON 21/18L

Handwritten marks and scribbles on the left margin.

Faint, mostly illegible text in the center of the page, possibly bleed-through from the reverse side.

Faint text at the bottom of the page, likely bleed-through from the reverse side.

159003

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 2 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Anna MIDDLE B. LAST RUTH			7a. DATE OF DEATH MONTH DAY YEAR July 11, 1985		7b. HOUR 4:21A <sub>M</sub>			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 7 29 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. STATE MARYLAND			13b. COUNTY BALTO		13c. CITY OR TOWN ROSEDALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 1208 62nd ST 21237			15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE --- LAST REINSFELTER					
14. FATHER'S NAME FIRST FRANK MIDDLE --- LAST MARTIN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS MICHAEL F. RUTH 8105 DuVALL AVE.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from June 19 19 85, to July 11 19 85, that (we) last saw the deceased alive on July 11 19 85, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) did (not) view the body after death.								
22b. SIGNATURE Julio Schwartzman				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/11/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Julio Schwartzman, MD				22e. ADDRESS 9000 Franklin Square Drive, 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/15/85		23c. NAME OF CEMETERY OR CREMATORY GARDENS of FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO MD		
24. FUNERAL DIRECTOR NAME ADDRESS G. E. Galt 1241 Chesapeake Ave				25a. DATE REC'D. BY REGISTRAR JUL 12 1985		25b. REGISTRAR'S SIGNATURE ina Davidson-Randall		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2000



20% COTTON FIBER

20% COTTON FIBER

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked "N", then item 18 should not be filled in.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		85		18921							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR MIN	
Walter		J		Rutkowski				July 5, 1985		5:40 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		May 20 1904		81 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				Baltimore county MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		St. Josephs Hospital				Florist		Self-Employ.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Md.		-		Balto.				3234 Belair Rd. 21213			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
William Rutkowski				Mary Siemek							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO		219-18-4126		-A Frances Rutkowski		3234 Belair Rd. 21213					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CARDIO MYOPATHY, ISCHEMIC SEVERE											
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PLEURAL EFFUSION, BILATERAL; CARDIAC CACHEXIA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that N (this hospital) attended the deceased from 06-21-85 to 07-05-85, that N (we) lost saw the deceased alive on 07-05-85, and that in N (we) (did) (did not) view the body after death.											
22b. SIGNATURE DEGREE						22c. DATE SIGNED					
Cesar Gamboa MD						7-5-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
CESAR GAMBOA, MD.						3440 BELAIR RD BALTO MD 21213					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY		23e. MD.			
Burial		7-8-85		New Cathedral		Baltimore					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Schimunek Funeral Home, Inc.				JUL 09 1985				John Darden			



100-105

COLLECTIONS

RECEIVED

CLKS

NOT A RE...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked 0, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 2 2  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARK CHRISTOPHER ST. LEGER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 8 85</b>		2b. HOUR <b>11 A M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 14, 1964</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>21</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD	
10. CITY OR TOWN OF DEATH <b>Reisterstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HEALTH FACILITY, GIVE STREET ADDRESS) <b>Rosewood State Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>MD</b>			13b. CITY OR TOWN <b>Baltimore</b>	13c. STREET ADDRESS <b>Rosewood St. Hosp. Reisterstown Rd., 21117</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James M. St. Leger, Jr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary L. Schanze</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>1</b>		17. INFORMANT ADDRESS <b>James M. St. Leger, Jr., Ocean City, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio-respiratory distress</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hydrocephalic with Profound MR</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>Aug. 1981</u> to <u>July 1985</u> , that (1) (we) last saw the deceased alive on <u>July 8</u> 19 <u>85</u> , and that in my (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>R. GAUJAR</u>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/8/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. GAUJAR</b>		22e. ADDRESS <b>Rosewood Centre Owings Mills</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>7/10/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Saters Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lutherville, MD</b>	
24. FUNERAL DIRECTOR <b>Henry W. Jenkins &amp; Sons Co.</b> <b>4905 York Road Balto., MD 21212</b>			25. DATE REC'D BY REGISTRAR <b>JUL 11 1985</b> REGISTRAR'S SIGNATURE <u>[Signature]</u>		

BP

the scientific

214095

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 2 3  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nellie Sanford			2a. DATE OF DEATH MONTH DAY YEAR July 24 1985			2b. HOUR (11:49 AM)			
1. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 03 01 96		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Towson MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care N. Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY Home maker	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN Maryland Harford Abingdon			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13c. STREET ADDRESS & ZIP CODE 3007 Philadelphia Rd. 21009		
14. FATHER'S NAME FIRST MIDDLE LAST Frank Romenske			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marian Barczak			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-22-6201			17. INFORMANT Mrs. Norma Hammond, Balto. Md.			ADDRESS 8506 Kings Ridge Rd. 21234		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular disease years DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--	---	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Pneumonia

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>personally</del> attended the deceased from 31 May 1985, to 24 July 1985, that (I) <del>was</del> last saw the deceased alive on 24 July 1985, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) (do not) view the body after death.							
22b. SIGNATURE Walter T. Kees				DEGREE MD		22c. DATE SIGNED 24 July 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter T. Kees				22e. ADDRESS Monkton, Md			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-27-1985		23c. NAME OF CEMETERY OR CREMATORY St. Stephen's Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Bradshaw Baltimore Md.	
--	--	------------------------	--	--	--	--	--

24. FUNERAL DIRECTOR NAME Lester F. H 11750 Belair Rd		Kingsville, Md. 21087		25a. DATE REC'D. BY REGISTRAR JUL 30 1985		25b. REGISTRAR'S SIGNATURE L. E. K. R. R.	
---	--	-----------------------	--	--	--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1911

1912

1913

...

...

...

...

...

...

...

...

...

...

...

...

...

...

214034

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 9 2 4  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Joseph Leo Schlepner</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 27, 1985</b>			2b. HOUR <b>5:06p</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 14 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Self</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Emp.</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Essex</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6 Helena Ave. 21221</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George A. Schlepner</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amelia Shawen</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>Marlyn Schlepner 6 Helena Ave 21221</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Advanced Atherosclerotic Coronary Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>July 27</b> , 19 <b>85</b> , to <b>July 27</b> , 19 <b>85</b> , that (we) last saw the deceased alive on <b>July 27</b> , 19 <b>85</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Edward Bessman</i>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7-27-1985</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edward Bessman, M.D.</b>			22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/31/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rossville Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Connelly Funeral Home</b>			ADDRESS <b>300 Mace Ave 21221</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 31 1985</b>		25b. REGISTRAR'S SIGNATURE <i>John P. ...</i>		

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

480125

8



150043

1. FOR STATE REGISTRAR 9/5/85 rja

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

REG. NO.

1 8 9 2 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN BAKER SCHNEEMAN, JR.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7 11 '85</b>		2b. HOUR M <b>5:30AM</b>	
3 SEX <b>MALE</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 4, 1898</b>	
6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b>		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b>		MD.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTIMORE MEDICAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Assist. Treasurer</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Carroll Independent Fuel Co.</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>226 Hopkins Rd. 21212</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>John B. Schneeman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-03-6588A</b>		17 INFORMANT ADDRESS <b>Mildred B. Tidwell 3925 Beech Ave. Baltimore, Md. 21211</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>CARDIAC ARREST</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 MIN.</b>
IMMEDIATE CAUSE (a)					
DUE TO, OR AS A CONSEQUENCE OF (b)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CHRONIC OBSTRUCTION PULMONARY DISEASE, PERFORATED CECAL CARCINOMA</b>					
19a. DATE OF OPERATION <b>6/19 85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PERFORATED CECAL CARCINOMA</b>		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/19 85</b> to <b>7/11 85</b> , that (I) (we) last saw the deceased alive on <b>7/11 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Richard J. Karol</i>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/11/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD J. KAROL, M.D.</b>		22e. ADDRESS <b>GBMC-6701 CHARLES ST. (NORTH)</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 13, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Timonium, Balto. Co., Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>JUL 12 1985</b>		23f. REGISTRAR'S SIGNATURE <i>R. J. Karol</i>	
24 FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc.</b>		ADDRESS <b>6500 York Rd. Balto., Md. 21212</b>			

5





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

Film G607 item 1 7 16b

1- FOR  
STATE 9/5/85 rja  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 2 6  
REC. NO.

1. DECEASED NAME (LAST OR FIRST)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Anna		M		aka Schrieber SCHREIBER	July 4, 1985				6:40a M
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 1 YRS
Female	White		Dec. 12 1898		86		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Baltimore, Md.	USA				Baltimore County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Rossville 21237	Franklin Sq. Hospital				Housewife		Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. STREET ADDRESS / ZIP CODE				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Maryland Baltimore Essex					212 Nanticoke Rd. 21221				
4. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
John Donamann					Mary ?				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					213-74-5827		2101 Tred Avon Rd. Alice Marks, Daughter Balto., Md. 21221		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>EXACERBATION OF CHRONIC OBSTRUCTION PULMONARY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>CONGESTIVE HEART FAILURE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 17</u> , 19 <u>85</u> , to <u>July 4</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>July 4</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Omar Kayaleh M.D.</u>					DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>7/4/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Omar Kayaleh M.D.					9000 Franklin Square Dr.				
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		7/8/85		Gardens of Faith Cemetery		Baltimore Co., Md.			
24. FUNERAL DIRECTOR <u>Bruzdzinski Funeral Home PA 1407</u>					25a. DATE RECEIVED BY REGISTRAR <u>JUL 05 1985</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				



COLUMBIA UNIVERSITY

1955  
1956  
1957  
1958  
1959  
1960  
1961  
1962  
1963  
1964  
1965  
1966  
1967  
1968  
1969  
1970  
1971  
1972  
1973  
1974  
1975  
1976  
1977  
1978  
1979  
1980  
1981  
1982  
1983  
1984  
1985  
1986  
1987  
1988  
1989  
1990  
1991  
1992  
1993  
1994  
1995  
1996  
1997  
1998  
1999  
2000  
2001  
2002  
2003  
2004  
2005  
2006  
2007  
2008  
2009  
2010  
2011  
2012  
2013  
2014  
2015  
2016  
2017  
2018  
2019  
2020  
2021  
2022  
2023  
2024  
2025

199015

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 9 2 7  
REG. NO.1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George A. Schrenker			2a. DATE OF DEATH MONTH DAY YEAR 7 4 85			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 12 15		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Perry Hall		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8526 Vollmert Ave. 21236				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Martins	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE 8526 Vollmert Avenue 21236									
14. FATHER'S NAME FIRST MIDDLE LAST John Schrenker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Kunkel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 217-12-9826		17. INFORMANT ADDRESS Jo Anne Chyba 4303 Mispillion Rd. 21236					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE YEARS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11c.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature] DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 7/5/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Kleeman (296-1464)						22e. ADDRESS Osler Bldg. Towson, Maryland 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-8-85		23c. NAME OF CEMETERY OR CREMATORY St. Jos. Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Md.		
24. FUNERAL DIRECTOR NAME Lassano Funeral Home						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	

JUL 10 1985

John Kunkel - Registrar

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

214106

1- FOR  
STATE  
REGISTRARWILHELM F.  
SCHULZSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5  
REG. NO.

1 8 9 2 8

1. DECEASED NAME (TYPE OR PRINT) Wilhelm F. SCHULZ		2a. DATE OF DEATH MONTH DAY YEAR July 28, 1985		2b. HOUR 11:02 <sup>M</sup>	
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11 14 1906		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH ROSSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TOOL & DIE	12b. KIND OF BUSINESS OR INDUSTRY TOOL & DIE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTO	13c. CITY OR TOWN MIDDLE RIV	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1101 MIDDLEWAY RD APT. 2C 21220
14. FATHER'S NAME FIRST MIDDLE LAST --- --- ---		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST --- --- ---			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT ADDRESS S.E. WIIT 6109 HAMILTON AVE 21237	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF: (b) Marked pulmonary edema DUE TO, OR AS A CONSEQUENCE OF: (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 9, 19 85, to July 28, 19 85, that (I) (we) last saw the deceased alive on July 28, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Marlene J. Zetzer, MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARLENE J. ZETZER, MD		22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/31/85		23c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL	
23d. LOCATION CITY OR TOWN COUNTY STATE BEL AIR HARFORD MD		23e. DATE REC'D. BY REGISTRAR JUL 31 1985			
23f. FUNERAL DIRECTOR'S NAME Jeffrey		23g. ADDRESS 1211 Chesapeake Ave		23h. REGISTRAR'S SIGNATURE M. J. Zetzer	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

314308

10% COLICIN L125B

CHIEF IN CHARGE



200 (8.11)

150080

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 18929  
REG. NO.1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Blanche Savannah SCHUTZ				2a DATE OF DEATH MONTH DAY YEAR July 6, 1985				2b HOUR 5:20 a.m.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 3, 1892		6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10 CITY OR TOWN OF DEATH Rossville		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Dundalk		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 2906 Liberty Parkway 21222	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Henry McGee				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theodosia McKenny					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-74-4557		17 INFORMANT H112 Cedar Lane Eleanor S. Riffle Kingsville, MD 21087					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (b) New Onset Seizures DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 6-24 1985 to 7-6 1985, that I (we) last saw the deceased alive on 7-6 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (do) view the body after death.									
22b SIGNATURE Keith W. Parker MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED 7/6/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Keith W. PARKER				22e ADDRESS 9000 Franklin Square Dr. 21237					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 07/08/1985		23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d LOCATION Baltimore, Maryland STATE			
24 FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc. Dundalk, Md 21222				25a. DATE REC'D. BY REGISTRAR JUL 10 1985		25b REGISTRAR'S SIGNATURE [Signature]			



300000



20% COTTON FIBER

CHILFAM

100%



100% COTTON FIBER

100% COTTON FIBER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 1 8 9 3 0 REG. NO.	
1 - FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) Grace Josephine Schutz						2a. DATE OF DEATH MONTH DAY YEAR July 7, 1985		2b. HOUR M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Dec. 22, 1883		6. AGE (IN YEARS LAST BIRTHDAY) 101 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co., MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 233 Rodgers Forge Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 233 Rodgers Forge Rd. 21212			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Jefferson Reilly				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Courson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - - - -		17. INFORMANT Mrs. Charles Mitchell		ADDRESS 104 Cross Keys Rd. -10					
18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <u>JAN 1</u> 19 <u>85</u> , to <u>JULY 7</u> 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>JULY 6</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did, did not) view the body after death.											
22b. SIGNATURE <u>Walter R. Welzant</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/8/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter R. Welzant, M.D.				22e. ADDRESS 6100 York Rd., Baltimore, MD 21212							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 7/9/85		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC.				ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR JUL 9 1985		25b. REGISTRAR'S SIGNATURE			

BP

1. The first part of the report is a general  
description of the project. It includes a  
brief history of the project and a statement  
of the objectives. The second part of the  
report is a detailed description of the  
methodology used in the study. This includes  
a description of the data collection methods  
and the statistical analysis used. The third  
part of the report is a discussion of the  
results of the study. This includes a  
comparison of the results with the objectives  
of the study and a discussion of the  
implications of the findings. The final part  
of the report is a conclusion and a list of  
references.

The first part of the report is a general  
description of the project. It includes a  
brief history of the project and a statement  
of the objectives. The second part of the  
report is a detailed description of the  
methodology used in the study. This includes  
a description of the data collection methods  
and the statistical analysis used. The third  
part of the report is a discussion of the  
results of the study. This includes a  
comparison of the results with the objectives  
of the study and a discussion of the  
implications of the findings. The final part  
of the report is a conclusion and a list of  
references.





211086

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 9 3 2  
REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ESTHER E SCOTT</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7/22/85</b>		2b. HOUR <b>7<sup>12</sup> M</b>	
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 28 1902</b>	
6 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH'S HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. STREET ADDRESS / ZIP CODE <b>6234 Falls Road Baltimore, Maryland 21209</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>William W. Scott</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Henrietta Green</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>	
16b. SOCIAL SECURITY NO. <b>220-20-4021</b>		17. INFORMANT <b>Marie S. Brown</b>		ADDRESS <b>6203 Falls Road Baltimore, Maryland 21209</b>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest. (3) 4</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA (3) Acute GI-Bleed: 2nd</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Myocardial Infarct</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>			

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from <b>7/10</b> 19 <b>85</b> , to <b>7/22</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>7/20</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.					
22b. SIGNATURE <b>Bryan K. Jankoff</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/22/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B.K. Jankoff</b>		22e. ADDRESS <b>7600 Osler Dr. 21209</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/27/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. National Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel, Maryland</b>	
24. FUNERAL DIRECTOR (NAME) <b>Nutter &amp; Sons Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 26 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Pendell</b>	
2501 Gwynns Falls Parkway, N Balto. Md. 21216							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

170115

170115

170115

Black

White

Black

Domestic

170115

170115

170115

170115

170115

170115

170115



170115

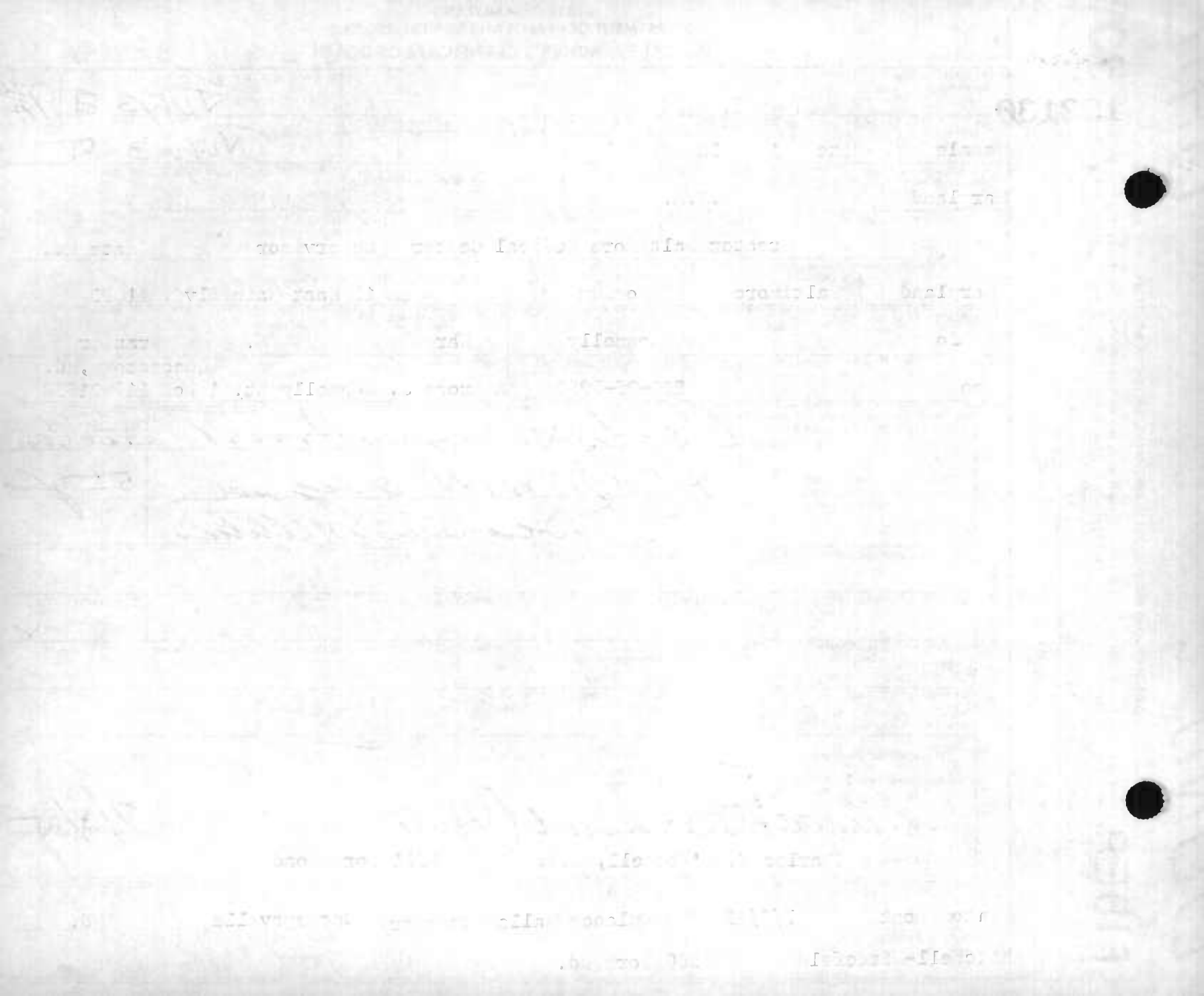
170115

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURLING, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18933									
1. DECEASED NAME (TYPE OR PRINT) MARY E. SCOVERN										2a. DATE KNOWN OF DEATH ESTIMATED July 3 1985										2b. DATE OF DEATH ESTIMATED July 3 1985										2c. DATE PRONOUNCED DEAD July 3 1985									
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 1 DAY 30 YEAR 09		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD July 3 1985										7d. HOUR 9:30																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.									
10. CITY OR TOWN OF DEATH TOWSON										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor										12b. KIND OF BUSINESS OR INDUSTRY State Md.									
13a. STATE Maryland										13b. CITY Baltimore		13c. CITY OR TOWN Timonium		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 13 East Main Blvd. 21093																							
14. FATHER'S NAME FIRST John MIDDLE LAST Donnelly										15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE E. LAST Brazier																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no										16b. SOCIAL SECURITY NO. 220-05-7998										17. INFORMANT ADDRESS Queenstown, Md. Ambrose J. Donnelly Rt. 1 Box 217 21658																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cocaine-Pulmonary Arrest</u> (b) <u>ASCD with original</u> (c) <u>8 Diabetes Mellitus</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 5+ yrs																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> (TYPE OR PRINT) Charles F. O'Donnell, M.E.										TITLE (SPECIFY) Deputy MEDICAL EXAMINER										DATE SIGNED 7/3/85																			
EXAMINER'S NAME (TYPE OR PRINT) Charles F. O'Donnell, M.E.										ADDRESS 7501 York Road																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment										23b. DATE 7/6/85										23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery										23d. LOCATION CITY OR TOWN COUNTY STATE Cocksவில் Md.									
24. FUNERAL DIRECTOR Mitchell-Wiedefeld										ADDRESS 6500 York Rd.										25a. DATE REC'D. BY REGISTRAR JUL 9 1985										25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>									

BP







226041

Film 6607 item 13e, 18

FOR  
1- STATE 9/5/85 rja  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH85  
REG. NO.022351  
18934

1. DECEASED NAME (TYPE OR PRINT) <b>Todd</b>		MIDDLE <b>W.</b>		LAST <b>Seabold</b>		2a. DATE OF DEATH MONTH <b>7</b> DAY <b>5</b> YEAR <b>85</b>		2b. HOUR <b>9:56</b> M.	
3. SEX <b>M</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>15</b> YEAR <b>44</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>40</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>GLYNDON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) <b>12 WORTHINGTON HILL DRIVE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Banker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>VICE PRES.</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>GLYNDON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>445 W. 23rd St. 10001</b>	
14. FATHER'S NAME FIRST <b>W. Ham</b> MIDDLE <b></b> LAST <b>Seabold</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Dorothy</b> MIDDLE <b></b> LAST <b>Shoemaker</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-44-7768</b>		17. INFORMANT <b>DR. G. WILLIAM SEABOLD GLYNDON, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <b>B Kaposi's Sarcoma</b> DUE TO, OR AS A CONSEQUENCE OF <b>C Acquired Immune Deficiency Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF <b>A Renal Failure</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>1 year</b> <b>2 week</b>	
PART II. OTHER IMPORTANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Cytomegalovirus and Colitis, Reined Herpes simplex</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (we) (we) did not view the body after death.									
22b. SIGNATURE <b>Richard D. Leavitt</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/6/85</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>JUL 7, 85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CARROLL CREMATION</b>		23d. LOCATION CITY OR TOWN <b>HAMPSTEAD, MD.</b> COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>ELINE FUNERAL HOME</b> ADDRESS <b>REISTERSTOWN, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 10 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner's certificate must be filed with this certificate within 24 hours after death. Page 4 must be filed with this certificate.

SS8041

W.

WHITE

AGE

BAL

VICE PRES.

INGTON HILL DRIVE

15 WORTHINGTON HILL DR. S1024

BALTO.

SHOEMA

WILLIAM SEABOLD GLYNDON, MD.

D.

NO

CREMATION JUL 7, 82 CARROLL CREMATION HAMPSHIRE, MD.

ELINE FUNERAL HOME REISTERSTOWN, MD.

204131

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 18935  
REC. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HARRIETT</b>		FIRST MIDDLE LAST <b>SEGALL</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7 10 85</b>		2b. HOUR <b>905 P M</b>	
3. SEX <b>F FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 20, 1936</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>OWINGS MILLS</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MORRIS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IRENE COHEN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>215-82-9788</b>		17. INFORMANT ADDRESS <b>MRS. SUSAN LEFKO</b>		17. ADDRESS <b>15 PACERS LANE BALTO., MD</b>		21208	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic Ketoacidosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7-10-85</b> to <b>7-10-85</b> , that (I) (we) last saw the deceased alive on <b>7-10-85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (or) (d) (did not) view the body after death.							
22b. SIGNATURE <b>Raymond</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>7.10.85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAYMOND GOVINDA RAJ</b>				22e. ADDRESS <b>Baltimore County GEN HOSPITAC</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JULY 11, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANSHE EMUNAH</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS INC</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1985</b>		25b. REGISTRAR'S SIGNATURE <b>one Davidson Randall</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove both this page, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10103

20 20 20

20 20 20

20 20 20

213092

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 9 3 6  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LILLIAN D. SEIDENBERG</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 25, 1985</b>		2b. HOUR <b>6:10A.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 22, 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY CO. MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3653 FOREST HILL RD. 21207</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>3653 FOREST HILL RD. 21207</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY GERSON LEVENSON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARAH KARKLIN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-20-8521</b>		17. INFORMANT ADDRESS <b>MR HARRY SEIDENBERG 3653 FOREST HILL RD. 21207</b>			
18. CAUSE OF DEATH Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic breast cancer</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>5/9/85</b> to <b>7/25/85</b> , that (I) (we) last saw the deceased alive on <b>5/9/85</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE <b>Dr. Leonard Lichtenfeld</b>				22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <b>7/25/85</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. LEONARD LICHTENFELD</b>				22f. ADDRESS <b>2435 W. BELVEDERE AVE.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/26/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH YEHUDA CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 30 1985</b>			
25b. REGISTRAR'S SIGNATURE <b>J. H. Davidson</b>				25c. ADDRESS <b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

SECCAS



1204117

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 95

REG. NO.

37

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
RUSSELL THOMAS SELVEY				JULY 13, 1985		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
MALE	WHITE	MONTH DAY YEAR		75		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
WEST VA.		U.S.A.				BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		2730 WALDOR DR		EXPEDITOR			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Md		BALTIMORE		BALTIMORE						2730 WALDOR DR 21234	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		NO		232-10-8992		Avis E. Selvey		2730 WALDOR DR.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:		MINUTE	
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST			
DUE TO, OR AS A CONSEQUENCE OF			
(b) SEVERE ASCUED COMPLEX VENTRICULAR any rhythm		Weeks	
DUE TO, OR AS A CONSEQUENCE OF			
(c) SEVERE ARCUO		Years	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/5 1985 to 7/5 1985 that (I) (we) last saw the deceased alive on 7/5 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		BARRY WORTH M.D.		MD		7/15/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR		22g. REGISTRAR'S SIGNATURE	
BARRY WORTH M.D.		2003 ROCKSPRING RD FORT HILL, MD 21050		JUL 16 1985		John Davidson-Randall	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		JULY 17, 1985		GARDENS OF FAITH		BALTIMORE MD.	

24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HARTLEY MILLER		JUL 16 1985		John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardholders. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

37

10-11-12

Class 11 Thomas St. St.

Math 11

West Van 11

Calculus 11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11



190007

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 9 3 8

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marion Stanley Shalcosky, Jr.			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 7/ 3/ 19 85			2b. HOUR M 12:45 P M		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 9/19/42	6. AGE (IN YEARS) (LAST BIRTHDAY) 42 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. DATE PRONOUNCED DEAD MONTH DAY YEAR 7/ 3/ 19 85	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? —		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) I-695 Key Bridge Causeway			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Apprentice Clerk		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. STATE Md.		13b. COUNTY Baltimore		13c. STREET ADDRESS 1632 E. Fort Ave.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Maria S. Shalcosky Jr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE BRANCH AND DATES) Yes			16b. SOCIAL SECURITY NO. 21740-8628			17. INFORMANT Name Address Helma Shalcosky 1632 E. Fort Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:57x 7/ 3/1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver of toll facility pick-up truck, crossed center line, struck by tractor trailer			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bridge		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Key Bridge Causeway, Sparrows Pt., Balto. Co., Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE [Signature]			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 7/4/85		
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.			ADDRESS 111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (IF BY)			23b. DATE 7/6/85		23c. NAME OF CEMETERY OR CREMATORY Lafayette Cross Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis Md.	
24. FUNERAL DIRECTOR NAME Charles L. Stevens			25. DATE REC'D. BY REGISTRAR JUL 05 1985		26. REGISTRAR'S SIGNATURE [Signature]			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHWH - 17  
(VR A15 ME (5))

100

100

100

100

100

100

100

159081

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH85 18939  
REC. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virginia Frances Sheetenhelm			2a. DATE OF DEATH MONTH DAY YEAR July 8, 1985		2b. HOUR 11:15pm
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 4 1899		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care - Rossville		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST John Lewis Robertson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie Ann Ford		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213/07/6246	17 INFORMANT ADDRESS Wilson S. Plott 3123 Dunglew Rd. 21222			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>UTI</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Severe Senescence</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/14</u> , 19 <u>81</u> , to <u>7/8</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>6/14</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>N. Haroun</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/9/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Nadji J. Haroun		22e. ADDRESS 901 Eastern Blvd. Essex, Maryland 21221			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/11/1985	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion U. Meth. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Pleasant Frederick, Md.	
24 FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc. Balto., Md. 21222		25a. DATE REC'D. BY REGISTRAR JUL 10 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



100-100000

WILKINSON

OFFICE OF THE ATTORNEY GENERAL

TO THE HONORABLE

217066

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT FORM. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 8 9 4 0	
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME FIRST MIDDLE LAST <b>JASON SHIMONKEVITZ</b>										X MONTH DAY YEAR <b>7-28-85</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>06-27-85</b>		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN <b>1 1</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7-28-85</b>		2d. HOUR <b>10:30A</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>		
10. CITY OR TOWN OF DEATH <b>Woodlawn</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7045 Rudisill Ct. Apt 1 A</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Child</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Woodlawn</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>Apt. 1 A 7045 Rudisill Court 21207</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Shimonkevitz</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bonnie Scannell</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>						16b. SOCIAL SECURITY NO. <b>-----</b>					
17. INFORMANT <b>Mr. and Mrs. Charles Shimonkevitz</b> <b>7045 Rudisill Court Apt. 1 A Balto. 21207</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden infant death syndrome</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) <b>Assistant</b>				DATE 7-29-85 SIGNED			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7/30/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Mem. Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville Carroll MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Eoring Byers Funeral Directors, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 1 1985</b>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Rondelet</i>			
ADDRESS <b>8728 Liberty Road Randallstown, MD. 21133</b>											

93813 101100

000000

11/17/71



000000

VOIDED DEATH CERTIFICATE NUMBER 85-18941





207082

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8518942  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>AUGUST (BUD) E SIMA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 20 1985</b>			2b. HOUR MIN. <b>9:45 A.M.</b>				
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 27 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		6. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTD. COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) <b>14 RIDGE RD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>POST SR. SERVICE FT. MEADE</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>			13b. COUNTY <b>BALTD</b>		13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>14 RIDGE RD 21228</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>AUGUST E SIMA</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELSIE BRAUN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII 215-16-1200</b>		17. INFORMANT ADDRESS <b>ELIZABETH SIMA 14 RIDGE RD.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory ArrestAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHImmediateConditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Spontaneous Lung Ca

DUE TO, OR AS A CONSEQUENCE OF

(c) Smoking

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/12</u> , 19 <u>82</u> , to <u>7/21</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>7/17</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE <u>Wm C Waterfield</u>		DEGREE <u>MD</u>		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED <u>7/22/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Wm C Waterfield</u>		22e. ADDRESS <u>Sr Agnes Hospital</u> <u>900 Caton Ave Balt 21229</u>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/23/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CRESTLAWN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>HOWARD MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>WEBER FUNERAL HOME</b>		ADDRESS <b>EDMONDSON AVE</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 22 1985</b>		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REPORT OF THE  
COMMISSIONER OF THE  
LAND OFFICE  
STATE OF NEW YORK  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 1, 1900  
ALBANY: J.B. LIPPINCOTT & CO.  
1900

ALBANY: J.B. LIPPINCOTT & CO.  
1900

1.93044

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 4 3  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Agnes SITO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 4, 1985</b>			2b. HOUR <b>2:35 a.m.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 11 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>69</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>ROSEDALE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQUARE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN SITO</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA DRAG</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			
16a. SOCIAL SECURITY NO. <b>214 05 3595</b>			17. INFORMANT ADDRESS <b>THERESA SADOSKY 8015 SACAMORE RD</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest from Abdominal Distention with occluded Kaminski Tube</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pre Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Decubitus ulcers of Hip and Sacral Area</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (he) (this hospital) attended the deceased from <b>July 1</b> , 19 <b>85</b> , to <b>July 4</b> , 19 <b>85</b> , that (he) (we) last saw the deceased alive on <b>July 4</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Sompalli Prasad</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>7/4/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sompalli Prasad, M.D.</b>						22e. ADDRESS <b>9000 Franklin Sq. Dr., 21237</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>7/8/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS</b>		23d. LOCATION CITY OR TOWN COUNTY <b>BALTIMORE MD.</b>		
24. FUNERAL DIRECTOR NAME <b>RAYMOND L. KACZOROWSKI</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 8 1985</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



217112

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 3 9 4 '4  
REG. NO.1- FOR  
STATE  
REGISTRAR

8-6-85 Item 4, 7a, 13, 15 L.U.

1 DECEASED NAME (TYPE OR PRINT) <b>Ryan SMITH, BABY BOY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-28-85</b>			2b. HOUR <b>2:00AM</b>			
1.5 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 27, 1985</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>7 1 2</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN. <b>2 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.			
10 CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC. 6701 N. CHARLES ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Michael Anthony Cole</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nancy Patricia Smith</b>			13e. STREET ADDRESS / ZIP CODE <b>1723 Pinoak Road 21234</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS <b>Birth record</b>					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **EXTREME PREMATUREITY**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**2 HRS. 4 MIN.**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/27</b> , 19 <b>85</b> , to <b>7/28</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>7/28</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>James D. Day</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>7/28/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James D. Day</i>		22e. ADDRESS <b>GBMC 6701 N. CHARLES</b>					

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7/29/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GBMC</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>	
24 FUNERAL DIRECTOR <i>R. J. Smith</i>		ADDRESS <i>GBMC</i>		25a. DATE REC'D. BY REGISTRAR <b>AUG 01 1985</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

311115

7-28-82 12:00A

SMITH, BARRY RAY

BALTIMORE COUNTY

1000 N. CHARLES ST.

TOWSON

EXTREME PREMATURITY



82

7/28

82

7/28

82

7/28

1000 N. CHARLES ST.

TOWSON

159100

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 8 9 4 5

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA SMITH</b>			2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> 7 DAY 6 YEAR 1985			2b. HOUR 0310 M			
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 8 DAY 19 YEAR 08	6. AGE (IN YEARS) LAST BIRTHDAY 76 YRS	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH 7 DAY 6 YEAR 1985			2d. HOUR 1310 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8208 Northview Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8208 Northview Rd. 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Not Known Zacharda				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Known					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 216-18-9963		17. INFORMANT ADDRESS Mr. Richard K. Smith Same as 13e			
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic ischemic myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE J.C. Rossan			M.D. <u>Deputy</u>			MEDICAL EXAMINER		DATE SIGNED 7/6/85	
EXAMINER'S NAME (TYPE OR PRINT) J.C. Rossan			ADDRESS 2112 Dundalk Ave. Balb., Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/9/85		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland 21222		
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck Funeral Home 7922 Wise Ave. 21222					25a. DATE REC'D. BY REGISTRAR JUL 10 1985		25b. REGISTRAR'S SIGNATURE [Signature]		



1000



4/4

1000 28 3 7

17.02

1000

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

1000

1000



1000



203338

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 4 6  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ella R. SMITH			2a. DATE OF DEATH MONTH DAY YEAR June 29, 1985			2b. HOUR 7:00p M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept 27 1930		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8445 Palasky Highway	
14. FATHER'S NAME Albert				15. MOTHER'S MAIDEN NAME Myrtle		16. ADDRESS Tasker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 234 46 6721		17. INFORMANT Paul B. Smith - Baltimore Md					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic Renal Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 16 19 85, to June 29 19 85, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on June 29 19 85, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and on the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE Keith English, M.D.				DEGREE MD		22c. ADDRESS 9000 Franklin Square Drive Balto. 21237	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Keith English, M.D.				22e. ADDRESS 9000 Franklin Square Drive Balto. 21237		22f. DATE SIGNED 6/29/85	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-2-85		23c. NAME OF CEMETERY OR CREMATORY Philos Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Westport Allegany Md	
24. FUNERAL DIRECTOR NAME Harry W. Haight				ADDRESS Sykesville, MD		25a. DATE REC'D. BY REGISTRAR JUL 10 1985	
				25b. REGISTRAR'S SIGNATURE John Davidson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

05330

0. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. The first thing I noticed when I stepped out of the plane was the cold. It was a sharp contrast to the warm air of the airport. I pulled my coat tighter around me and looked out at the snow-covered landscape. The trees were bare, their branches reaching out like skeletal fingers against a pale, overcast sky. A few distant figures could be seen walking along the path, their breath visible in the chilly air. I felt a sense of isolation, as if I had been transported to a different world. The silence was broken only by the occasional crunch of snow underfoot and the distant hum of an engine. I took a deep breath, trying to clear my mind of the chaos of the city I had just left behind. The snow seemed to have a soft, almost ethereal quality to it, covering everything in a thick, white blanket. I walked slowly, savoring the quiet solitude of the winter day. The cold was invigorating, a welcome change from the stifling heat of the summer months. I felt a sense of peace, a momentary escape from the pressures of daily life. The snow-covered ground beneath my feet felt like a soft, yielding surface, a reminder of the gentle touch of nature. I continued my walk, the snow crunching under my shoes, the cold air filling my lungs. The world seemed to have slowed down, the hustle and bustle of the city replaced by a quiet, contemplative stillness. I felt a sense of connection to the natural world, a reminder of the beauty and resilience of nature in the face of the elements. The snow was a beautiful sight, a testament to the power of winter. It was a reminder that even in the coldest of months, there is still beauty to be found. I walked on, the snow crunching under my feet, the cold air filling my lungs. The world seemed to have slowed down, the hustle and bustle of the city replaced by a quiet, contemplative stillness. I felt a sense of connection to the natural world, a reminder of the beauty and resilience of nature in the face of the elements. The snow was a beautiful sight, a testament to the power of winter. It was a reminder that even in the coldest of months, there is still beauty to be found.



2. The second thing I noticed was the smell. It was a mix of the cold, crisp air and the faint, earthy scent of the snow. I had heard that the snow in this area was particularly pure, and now I could see why. The snow was a brilliant white, untouched by the grime and pollution of the city. It was a beautiful sight, a testament to the power of winter. I walked on, the snow crunching under my feet, the cold air filling my lungs. The world seemed to have slowed down, the hustle and bustle of the city replaced by a quiet, contemplative stillness. I felt a sense of connection to the natural world, a reminder of the beauty and resilience of nature in the face of the elements. The snow was a beautiful sight, a testament to the power of winter. It was a reminder that even in the coldest of months, there is still beauty to be found.

203384

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 4 7  
REG. NO.

|  |  |   |   |  |                              |   |  |   |  |  |  |
|--|--|---|---|--|------------------------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Elspeth B. Smith</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>7 12 85</i> |  | 2b. HOUR<br><i>5 20 A.M.</i> |   |  |   |  |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>8 8 07</i>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>77</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Md.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County MD.</i>                             |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Towson Md.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Mullis Medical Services of Towson</i> |   |  |                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Clerical</i>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Cont. Can</i>   |  |  |  |
| 13a. STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>Baltimore</i>   |   | 13c. CITY OR TOWN<br><i>Baltimore</i>  |                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>1014 Evesham Ave. 21211</i>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Martin</i>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Edith Fisher</i>   |                              |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>216-05-7024A</i>  |   | 17. INFORMANT<br>ADDRESS<br><i>Della Harris 2301 Pentland Dr. 21234</i>  |                              |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardio pulmonary Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Acute Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Cerebrovascular Accident</i>  |  |   |   |  |                              |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>1 min.</i><br><i>10 min.</i><br><i>3 days.</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.<br><i>Atherosclerotic Vascular Disease.</i>   |  |   |   |  |                              |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                              |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                              |   |  |   |  |  |  |
| 22a. I certify that (I) <i>(Signature)</i> attended the deceased from <i>December 19 89</i> to <i>July 12 19 85</i> , that (I) <i>(Signature)</i> lost<br>saw the deceased alive on <i>July 9 19 85</i> , and that in (my) <i>(Signature)</i> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <i>(Signature)</i> (did not) view the body after death. |  |   |   |  |                              |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>James H. Milman</i>   |  |   |   | DEGREE<br><i>MD</i>  |                              |   |  | 22c. DATE SIGNED<br><i>7/12/85</i>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>James H. Milman</i>  |  |   |   | 22e. ADDRESS<br><i>1205 York Rd, Lutherville, Md</i>   |                              |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>7-15-85</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Druid Ridge Cemetery</i>  |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Pikesville Balto. Md</i>                       |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Burgee-Henss Funeral Home</i>   |  |   |   | 24b. ADDRESS<br><i>3631 FALLS Rd. 21211</i>  |                              | 25a. DATE REC'D. BY REGISTRAR<br><i>JUL 16 1985</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jelia Davidson-Randall</i>   |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of office.

1. The first part of the report is a general survey of the situation in the country. It is a very good survey and gives a very good impression of the country.

2. The second part of the report is a detailed survey of the situation in the country. It is a very good survey and gives a very good impression of the country.

3. The third part of the report is a detailed survey of the situation in the country. It is a very good survey and gives a very good impression of the country.

4. The fourth part of the report is a detailed survey of the situation in the country. It is a very good survey and gives a very good impression of the country.

5. The fifth part of the report is a detailed survey of the situation in the country. It is a very good survey and gives a very good impression of the country.

6. The sixth part of the report is a detailed survey of the situation in the country. It is a very good survey and gives a very good impression of the country.

212050

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 4 8  
REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>George SMITH   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 10 1985   |  | 2b. HOUR<br>2:15 a                           |
| 3. SEX<br>male  | 4. RACE<br>white  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7-12-1898   | 6. AGE IN YEARS LAST BIRTHDAY<br>86   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hosp |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                     | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE CITY OR TOWN<br>Maryland Balto  |   |   | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13c. STREET ADDRESS / ZIP CODE<br>6116 Belair Rd 21206                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>218-32-462  |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Margaret Henderson 6116 Belair Rd 21206             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Ventricular Arrhythmia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Severe Pulmonary Edema<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (this hospital) attended the deceased from July 8, 19 85, to July 10, 19 85, that (we) last saw the deceased alive on July 10, 19 85, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br>Ralph P. Woodward   |   |   |   | 22c. DATE SIGNED<br>July 10, 1985  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ralph P. Woodward, M.D.  |   |   |   | 22e. ADDRESS<br>9000 Franklin Square Drive, 21237                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK #)<br>Burial  |   | 23b. DATE<br>7-18-85  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cem. Hampshire                        |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Baltimore Baltimore   |   | 23e. DATE REC'D. BY REGISTRAR<br>JUL 29 1985  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ 2222 W. North Ave  |   | 25. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell   |   |  |  |

MEDICAL CERTIFICATION

2

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



191005

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

1 8 9 4 9

REG. NO.

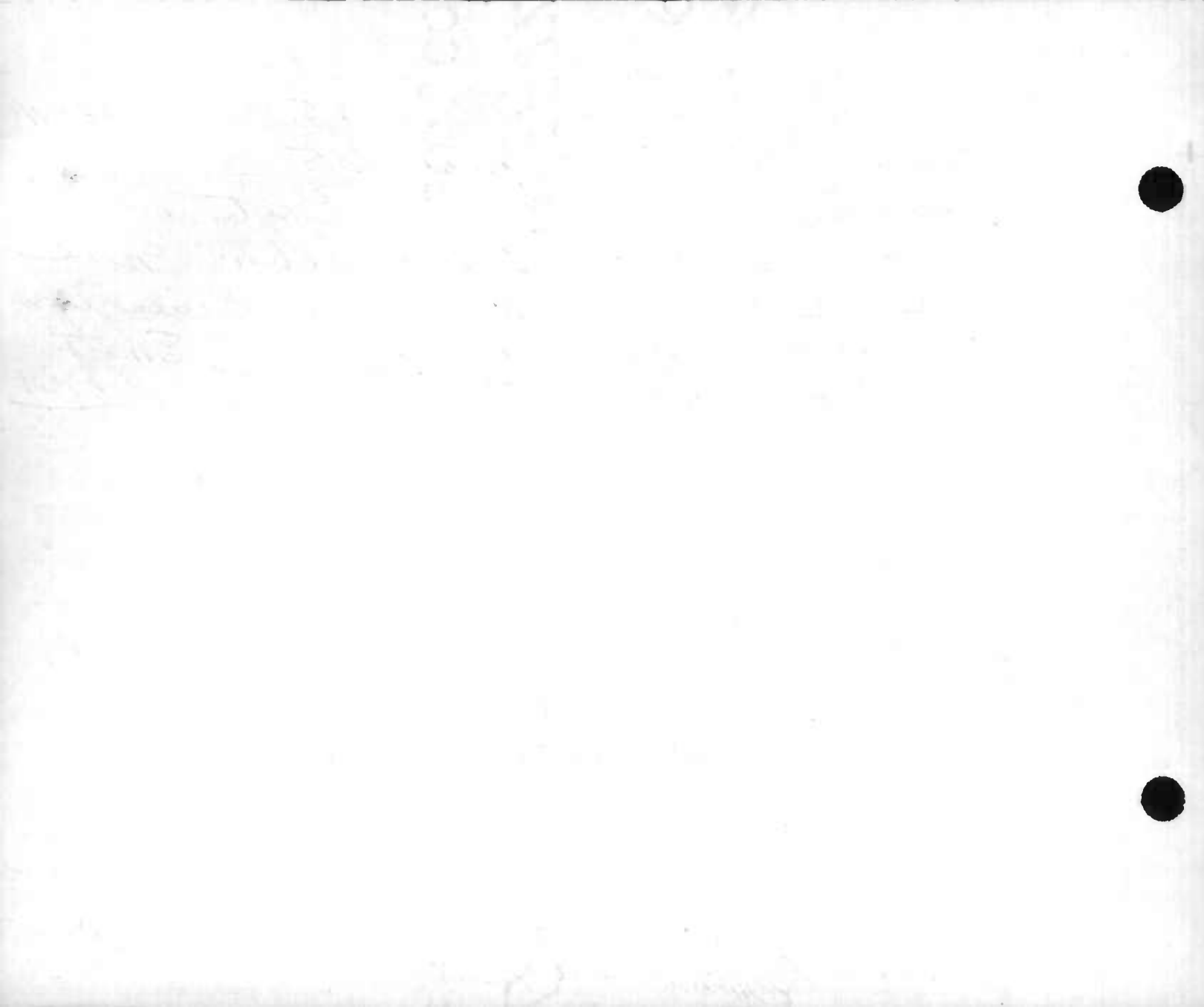
|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OF NAME) <i>James Lee Smith</i>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>7 5 85</i>  |  | 2b. HOUR<br><i>10 AM</i>   |
| 1. SEX<br><i>male</i>   | 4. RACE<br><i>Black</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>1 16 20</i>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>65</i>                                |  | IF UNDER 1 YEAR<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Sumter SC</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore</i> MD.                                    |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>USA</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>5263 Darnest Rd 21246</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Labor</i>                | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>none</i>                                     |  |
| 13a. STATE<br><i>MD</i>   | 13b. COUNTY<br><i>Harford</i>   | 13c. CITY OR TOWN<br><i>Baltimore</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><i>5263 Darnest Rd 21246</i>                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>James Lee Smith</i>  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Eliza Smith</i>   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>yes</i>  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><i>218-09 4181</i>  | 17. INFORMANT<br>ADDRESS<br><i>5263 Darnest Rd 21246</i>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac pulmonary arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Lung Cancer</i><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/12/85</i> , 19____, to <i>6/14/85</i> , 19____, that (I) (we) lost saw the deceased alive on <i>6/14/85</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><i>Peter P. Lai</i>   |   | DEGREE  |   | 22c. DATE SIGNED<br><i>7/8/85</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>PETER P. LAI, M.D.</i>  |   | 22e. ADDRESS<br><i>Johns Hopkins Hosp. Baltimore MD 21205</i>   |   |  |  |
| 23a. BURIAL CREMATION, REMOVAL<br>(SPECIFY)   | 23b. DATE<br><i>7/11/85</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lansdowne</i>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore MD</i>                    |  |
| 24. FUNERAL DIRECTOR<br><i>William L. Gorman</i>  |   | ADDRESS<br><i>3307 W. York Ave</i>  |   | DATE RECEIVED BY REGISTRAR<br><i>JUL 07 1985</i>                                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reburial.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_





206123

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8518950  
REG. NO.1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Wells Anthony Smith  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>July 18 1985 |   |  | 2b HOUR<br>M   |  |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 1 1915   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Timonium   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2 Buttrick Court, 21093 |  |   |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Fiscal Officer              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>State of Md.  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |  |  |  |
| 13a STATE<br>Maryland  |  | 13b COUNTY<br>Baltimore  |  | 13c CITY OR TOWN<br>Timonium  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS / ZIP CODE<br>2 Buttrick Court, 21093   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry Smith   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Rosenberger  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II  |  | 17 INFORMANT ADDRESS<br>Marguerite M. Smith, 2 Buttrick Ct., 21093  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cancer of the colon</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.               |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 months</u>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |  |  |   |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a I certify that (1) (this hospital) attended the deceased from <u>February 28</u> 19 <u>85</u> , to <u>July 19</u> 19 <u>85</u> , that (1) (we) lost saw the deceased alive on <u>July 16</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 27b. SIGNATURE<br><u>J. David Nagel</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>7-19-85  |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. David Nagel, M. D.   |  |  |  | 27e. ADDRESS<br>1205 York Rd., Lutherville, Md. 21093   |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>7/20/85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Timonium Balto. Md.                              |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Martin D. Lawson  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 22 1985  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Wellington, New Zealand

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

207139

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 5 1  
REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Georgia M. Snyder   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7 14 85  |   | 2b. HOUR<br>M   |  |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 17 10  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1265 Deanwood Rd. 21234 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Nurse |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Hospital Good Samaritan |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. STREET ADDRESS / ZIP CODE<br>1265 Deanwood Rd. 21234    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Skapik  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Masek   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-07-6734  |   | 17. INFORMANT<br>ADDRESS<br>Dogwood Court<br>James F. Snyder, Jr. Mahwah, N. J. 07430 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic melanoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                          |  |   |   |   |  |
| 22b. SIGNATURE<br><u>Stanley Morrison</u><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |   | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stanley Morrison, M. D. (837-0044)  |  |   |   | 22e. ADDRESS<br>11 E. Chase Street, Balto., Md.                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>7-15-85  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cemetery                          |  |
|  |  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lashawn Funeral Home   |  | ADDRESS<br>7401 Belair Rd.<br>BALTO. MD 21236   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 18 1985  |  |
| 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Rendall  |  |   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

10

57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be given to the funeral director, who should be selected for use as the burial transit permit. Their please remove carbon copies, Pages 1 and 2, and 2 should be filed within 72 hours after death. Page 3 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 9 5 2  
REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)<br>Mrs. Ruth H. Sollers  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>July 3 1985   |  | 2b. HOUR<br>6:45 P.M.   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>March 27 1916  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Realitor   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Real Estate  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Balto. City  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Robert Malcomb Hart  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Ruth E. Bandel  |  | 13e. STREET ADDRESS / ZIP CODE<br>3409 Alto Road 21216  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>216-05-1368   |  | 17. INFORMANT ADDRESS<br>Mrs. Ensor Clark 21207<br>5508 Windsor Mill Road Baltimore Maryland  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RENAL FAILURE - ANAEMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive HT failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>ANASARCA; Hypoproteinaemia.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-1</u> 19 <u>85</u> to <u>7-3</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7-3</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Govinda R. Govindaraj   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>7-3-85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Govinda R. Govindaraj  |  | 22e. ADDRESS<br>Balt. County Gen Hospital   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>07-06-85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Pikesville Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Road Randallstown, Maryland 21133  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 09 1985  |  | 25b. REGISTRAR'S SIGNATURE<br>John F. ...   |  |

BP

Cap 201



• • •

220 0 0 15



1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |  |  |  |  |  |   |  |
|---|--|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>James  |  | MIDDLE<br>A.  |  | LAST<br>SOUKUP   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 25, 1985   |  |  |  | 2b. HOUR<br>9:45 A.M.                           |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>AUG. 7 1900   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   |  |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                |  | 7b. IF UNDER 24 HRS.<br>HOURS MIN.              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Riveter          |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>MD.   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>500 N. KENWOOD AVE. 21205                          |  |  |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ALBERT SOUKUP   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY JANECEK   |  |  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>213-07-5978   |  | 17. INFORMANT<br>ADDRESS<br>9118 Waltham Wood Rd.<br>MRS. FRANK SHECKELS (NIECE) 21234  |  |  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute necrotizing pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Chronic lymphatic leukemia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0   |  |   |  |   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)   |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from July 22, 19 85, to July 25, 19 85, that (we) last saw the deceased alive on July 25, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Ralph Woodward  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>7-25-85  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ralph Woodward, MD   |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>7/29/85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bohemian National   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane, Balto. Md. 21213  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 30 1985   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson  |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death by the State Dept of Health and Mental Hygiene prior to burial, cremation, or resposal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP.

213002

10% COTTON FIBER



217067

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 5 4  
REG. NO.

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mrs. Margaret B. Spampinato</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 30 1985</b>                           |   | 2b. HOUR<br><b>1922</b> M   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>December 23 1899</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Maryland</b>   |   |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Rockdale</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Nikol</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Schreuer</b>            |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>213-74-8994</b>  |  | 17. HOME ADDRESS<br><b>Mr. John A. Spampinato</b><br><b>416 Sacred Heart Lane Reisterstown Maryland 21136</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>CONGESTIVE HEART FAILURE, VENTRICULAR ARRHYTHMIA</u> |   |   |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)     |  |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-16</u> , 19 <u>85</u> , to <u>7-30</u> , 19 <u>85</u> , that (I) (we) lost<br>saw the deceased alive on <u>7-30</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |  |   |   |
| 22b. SIGNATURE<br><u>Allen J. Chircus M.D.</u>  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>7-30-85</u>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Allen J. Chircus M.D.</u>   |   | 22e. ADDRESS<br><u>Balt. County General Hosp.</u>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>08-02-85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Park</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Skysville Carroll Maryland</b>   |   | 23e. DATE REC'D. BY REGISTRAR<br><b>AUG 1 1985</b>  |  |   |   |
| 24. BURIAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>  |   | ADDRESS<br><b>8728 Liberty Road Randallstown, Maryland 21133</b>  |  | 25. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>   |   |

MEDICAL CERTIFICATION

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and 3 should be filed with the funeral director. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



203517

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH85  
REG. NO.

18955

|   |  |   |  |   |  |   |   |  |  |  |
|---|--|---|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Janie B Spearman   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 15 85                         |   |  | 2b. HOUR<br>11:49 AM  |   |  |  |  |
| 3. SEX<br>F   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 9 23   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS                                 |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.             |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General Hosp. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Randallstown  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>3718 Live Oak Rd 21133 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ben Boykins   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Herring          |   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |   | 16b. SOCIAL SECURITY NO.<br>089-20-5163                                |   | 17. INFORMANT<br>ADDRESS<br>Stacy Spearman 3718 Live Oak Road  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic breast carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____    |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/14</u> , 19 <u>85</u> , to <u>7/15</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7/15</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |  |  |  |
| 27a. SIGNATURE<br><u>J. Boston</u>  |  |   |  |   | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 27c. DATE SIGNED<br>7/15/85  |  |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Boston  |  |   |  |   | 27e. ADDRESS   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  |   | 23b. DATE<br>7/20/85   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Spearman Family Cem.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Clinton, N.C.                                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>WM. C. March F.H. 1101 E. NORTH AVE   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 18 1985   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



159101

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 9 5 6  
REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |   |   |  |   |               |
|--|---|---|--|---|---------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John A. Staniewicz, Sr.</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-8-85</b> |   | 2b. HOUR<br>M |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7-6-1921</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b><br>YRS MONTHS DAYS HOURS MIN.                  |               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. Co.</b> MD.                               |               |
| 10. CITY OR TOWN OF DEATH<br><b>Middle River</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3517 Honeysuckle La.</b>                    |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Courier 1st</b> |               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Md.</b> |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br><b>3517 Honeysuckle La. 21220</b>                         |               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Staniewicz</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Antoinette Aczyinski</b>  |  |   |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                       |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII 220-03-2293</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Irene Staniewicz, Same as 13c</b>                            |               |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Cancer of Pn. crone*

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

*8 mo*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *no*

MEDICAL CERTIFICATION

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION<br><b>11/24/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cancer of Pn. crone</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN IDENTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/23/84</b> , 19 <b>84</b> , to <b>7/8</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>6/13</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Adam F. Szczypinski</i>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>7/6/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Adam F. Szczypinski, M.D.</b>   |  | 22e. ADDRESS<br><b>1422 E. Joppa Rd.</b>                                       |  |  |  |

|   |                             |   |  |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br><b>Burial</b> | 23b. DATE<br><b>7-11-85</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b> |
|---|-----------------------------|---|--|

|  |   |  |
|--|---|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b> | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 10 1985</b> | 25b. REGISTRAR'S SIGNATURE<br><i>John F. ...</i> |
|--|---|--|

2529-26

1910.

2018, 2019, 2020

- 9 -

5101C

— — —

9

•

• • •

03.01.2003

1978 6/17/78

... ..

Small and not colorful. In

334

still

5071 91bb:10

00910-14 of 14 (page 14 of 14)

1103

29199101

attained.

1007

1991-1992

1991-1992 2000-2001 2002-2003 2004-2005

• 10 月 10 日 • 星期日

• • • • •

FD-11-5

Account of the ...

non-*de* aff.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 9:24 PM  
REG. NO.FOR  
1 - STATE  
REGISTRAR

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FANNIE  |  | FIRST<br>MIDDLE<br>LAST<br>STERN   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>07-14-85  |  | 2b. HOUR<br>2:34 PM  |  |
| 3 SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07-05-1904   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE COUNTY GEN. HOSP. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN LEVIN   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CECELIA UNKNOWN  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>216-03-5421  |  | 17 INFORMANT HERBERT STERN<br>3925 SHENTON RD. RANDALLSTOWN, MD 21133  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure, DIABETIC<br>DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 07/05/85 to 07/14/85, that (I) (we) last saw the deceased alive on 07/14/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Kaushaleन्द्रक. S. Singh   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>7/14/85  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KAUSHALENDRAK. S. SINGH   |  |
| 22e. ADDRESS<br>BALTIMORE COUNTY<br>HOSPITAL   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  |  |  |  |
| 23b. DATE<br>JULY 16, 1985   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CHOFETZ CHAIM  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO. MD   |  | 24 FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215                   |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JUL 18 1985   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

203249

2422



RECEIVED  
MAY 11 1964  
FBI - NEW YORK



203521

1- FOR  
STATE REGISTRAR ROBERT J. STITHSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 5 3  
REG. NO.

|   |   |   |  |   |
|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Robert J. Stith</b>                              |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 17 85</b>   |  | 2b. HOUR<br><b>6:05 a.m.</b>  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 8, 1918</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                            | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD. |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Examiner - Social Security Adm.</b> | 12b. KIND OF BUSINESS OR INDUSTRY                                   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |   |   |  |   |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Catonsville</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 13e. STREET ADDRESS / ZIP CODE<br><b>1005 Crosby Road 21228</b>     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edwin Stith</b>                            |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marguerite Haggerty</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>      |   | 16b. SOCIAL SECURITY NO.<br><b>218-01-1622</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Bonnie Lee Stith same as # 13</b>    |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardiac Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Congestive Heart Failure**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Congestive Cardiac Myopathy**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-16</b> 19 <b>85</b> , to <b>7-17</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>7-17</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Allen J. Chiriac M.D.</b>   | DEGREE   | 22c. DATE SIGNED<br><b>7-17-85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Allen J. Chiriac M.D.</b>  | 22e. ADDRESS<br><b>Baltimore County General Hosp</b>                   |  |  |

|   |                             |  |  |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>      | 23b. DATE<br><b>7/19/85</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Veterans Owings Mills</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MD.</b> |
| 24. FUNERAL DIRECTOR<br><b>Leroy M. &amp; Russell C. Witzke</b> |                             | 25a. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JUL 18 1985</b>      |  |
| 1630 Edmondson Avenue, Catonsville, Md. 21228                   |                             |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper tags. Page 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified of case.

BP

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8518959  
REG. NO.FOR  
STATE  
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST  
CHARLES F. STROBEL

2a. DATE OF DEATH MONTH DAY YEAR  
7-5-85

2b. HOUR  
2:15 AM

3. SEX  
M

4. RACE  
W

5. DATE OF BIRTH MONTH DAY YEAR  
August 27, 1895

6. AGE (IN YEARS LAST BIRTHDAY)  
89 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Rochester, N. Y.

7b. CITIZEN OF WHAT COUNTRY?  
USA

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
BALTIMORE COUNTY MD.

10. CITY OR TOWN OF DEATH  
Towson Md.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Stella Maris Hospice - Towson 4. Md.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Salesman

12b. KIND OF BUSINESS OR INDUSTRY  
Sales

13a. USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE  
Md.

13b. COUNTY  
Baltimore,

13c. CITY OR TOWN  
Baltimore,

13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE  
350 Paddington Road 21212

14. FATHER'S NAME FIRST MIDDLE LAST  
Louis Strobel

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Catherine Miller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)  
Yes

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)  
WW 1 379 01 8377

17. INFORMANT ADDRESS  
Mrs. Marilyn S. Murray 350 Paddington Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Advanced ASCVD.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?  
YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial

23b. DATE  
7/9/85

23c. NAME OF CEMETERY OR CREMATORY  
Mansion Mem. Gardens

23d. LOCATION CITY OR TOWN COUNTY STATE  
Ellenton, Florida

24. FUNERAL DIRECTOR NAME ADDRESS  
MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.

25a. DATE REC'D. BY REGISTRAR  
JUL 9 1985

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers Pages 1 and 2 and deliver them within 72 hours after death to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 16 shows pay injury, or other traumatic event, the medical examiner must be notified of cause of death.

192063

RECEIVED  
JAN 27 1952

JAN 27 1952

RECEIVED

TO THE DIRECTOR

FROM THE

ADMINISTRATIVE

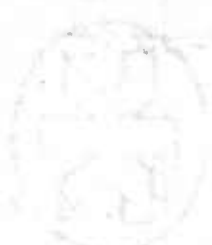
DEPARTMENT

RE: [illegible]

[illegible]

[illegible]

20% COPY



FOR THE DIRECTOR

ADMINISTRATIVE

DEPARTMENT

RE: [illegible]

192031

6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove the portion of the certificate containing the signature of the funeral director and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 9 6 0  
REG. NO.

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 1- FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR A. M.  |   |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Elizabeth Schomann Strott</i>  |  | <i>July 8, 1985</i>  |  | <i>9:10</i>   |   |
| 3. SEX<br><i>Female</i>  | 4 RACE<br><i>White</i>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>April 12, 1888 - 97</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br><i>97</i>   |   |
| 7a BIRTHPLACE (STATE OR FOREIGN)<br><i>Baltimore, Md.</i>  | 7b CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County, Md.</i>                                       |   |
| 10. CITY OR TOWN OF DEATH<br><i>Catonsville</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Summit Nursing Home</i> |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Homemaker</i>   |
| 13a. STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>Baltimore</i>  | 13c. CITY OR TOWN<br><i>Catonsville</i>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              | 13e STREET ADDRESS / ZIP CODE<br><i>110 Osborne Ave. 21228</i>  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Charles (Karl) Kreuder</i>   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Anna Margaretha Schomann</i>   |  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b SOCIAL SECURITY NO.<br><i>220-46-1585</i>  |  | 17 INFORMANT ADDRESS<br><i>Catonsville, Md. 21228.</i><br><i>Mrs. Hilda S. Hoffeditz-110 Osborne Ave.</i> |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>7 days</i>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><i>Congestive Heart Failure</i>  |  |  |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                            |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-5-1981</i> to <i>2-19-85</i> , that (I) (we) last saw the deceased alive on <i>2-19-85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |  |  |   |   |
| 22b. SIGNATURE<br><i>David R. Mosman, M.D.</i>   |  | DEGREE<br><i>M.D.</i>  |  | 22c. DATE SIGNED<br><i>7-8-85</i>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>David R. Mosman, M.D.</i>  |  | 22e. ADDRESS<br><i>5205 East Dr. Arbutus, Md. 21227</i>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>7/9/85</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Loudon Park Cemetery - Baltimore, Md.</i>                        |   |
| 23d. LOCATION CITY OR TOWN COUNTY STATE  |  | 23e. DATE REC'D. BY REGISTRAR<br><i>JUL 9 1985</i>   |  |   |   |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><i>Sterling Funeral Estate, P. A. 736 Edmondson Ave.; Catonsville, Md. 21228</i>  |  |  |  |   |   |

100-100000  
100-100000

Alfred H. Schumann

April 1, 1935 - 1935 - 1935

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

Alfred H. Schumann, Md.

207166

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 6 1  
REG. NO.

|   |  |   |  |   |   |  |  |  |
|---|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ELIZABETH MARIE SUGRUE   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JULY 21, 1985 |   |   | 2b. HOUR<br>10:22<br>P M   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 4, 1904  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81<br>YRS   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>204 E. Joppa Rd. |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Legal Secretary |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Attorney General N.Y. |  |
| 13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Towson  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles J. Sugrue   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Lynch   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>099-32-9303A   |  | 17. INFORMANT<br>ADDRESS<br>John R. Sugrue 102 Kennilworth Park Drive<br>Towson, Md. 21204  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIOSCLEROSIS<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/20/85 19, to 7/15/85 19, that (I) (we) lost saw the deceased alive on 7/15/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two or more persons view the body after death)   |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/><br>22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jamshid Hamed, M.D.  |  |   |  | 22c. DATE SIGNED<br>22e. ADDRESS<br>204 E. Joppa Rd. Towson, Md. 21204  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>July 24, 1985  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Calvary   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Long Island City N.Y.  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 24 1985  |   | 25b. REGISTRAR'S SIGNATURE<br>one Davidson-Randall   |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

042705

RECEIVED

20900





206120

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  | 85 REG. NO. 18962   |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Agnes Elizabeth Sullivan   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>July 18, 1985  |  | 2b. HOUR<br>11:15a   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 - 22 - 1893   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dulaney Towson Nursing Center |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Timonium  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Hanrahan   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Elizabeth Dailey  |  | 13e. STREET ADDRESS / ZIP CODE<br>237 East Timonium Rd. 21093  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>106-05-4639   |  | 17. INFORMANT ADDRESS<br>Rosemary S. Austin, 237 E. Timonium Rd   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.            |  |   |  |   |  |  |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January</u> 19 <u>81</u> to <u>July</u> 18, 19 <u>85</u> , that (I) (we) lost<br>saw the deceased alive on <u>June 7</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Isabelle MacGregor M.D.</u>  |  |   |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Isabelle MacGregor, M.D.   |  |   |  | 22e. ADDRESS<br>1818 Pot Spring Rd., Timonium, Md.  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>7/22/85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Timonium Balto. Md.   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Martin D. Lawson   |  |   |  | ADDRESS<br>Martin D. Lawson, 10 W. Padonia Rd.  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JUL 22 1985 <u>Julia Davidson-Randall</u>                                      |  |  |  |

BP



Handwritten notes and stamps, including a large 'B' stamp at the top center and various illegible markings throughout the page.

203175

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 18963

1. FOR  
STATE  
REGISTRAR

|   |  |  |   |   |  |  |  |   |  |
|---|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mary C. Summers  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>7-9-85 |   |  | 2b. HOUR<br>5p M   |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 20 06   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO. CITY  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO. COUNTY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>BLAND BRYANT NURSING HOME |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UNK.                 |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD. |  |  |   | 13b. CITY<br>BALTO  |  | 13c. CITY OR TOWN<br>BALTO   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>VINCENT UNK. KIRBY  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CLARA UNK. UNK.  |  |  |  | 13e. STREET ADDRESS / ZIP CODE<br>8701 EMIGE RD. BALTO 21204                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |  |   | 16b. SOCIAL SECURITY NO.<br>218-12-3399   |  | 17. INFORMANT<br>ADDRESS<br>DONALD V. Summers<br>16817 CLARK TERRACE<br>LAUREL, MD 20707 |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ca of cervix

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-17, 19-84, to 7-9, 19-85, that (I) (we) last saw the deceased alive on 7/9/85, 19-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>H. Devadoss   |  |  |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>7/9/85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. Devadoss  |  |  |  | 22e. ADDRESS<br>BB Bldg. Spangrove.   |  |   |  |

|   |  |                         |  |  |  |   |  |
|---|--|-------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(PECIFY)<br>BURIAL   |  | 23b. DATE<br>13 July 85 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cn.    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore BALT. Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Fleck Funeral Home Inc. |  |                         |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 11 1985               |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell    |  |                         |  | 25c. ADDRESS<br>7601 Sandy Spring Rd.<br>Laurel, Md. 21107 |  |   |  |

20% COLIC 100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

210222

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 1 8 7 6 4

|  |  |  |  |   |                      |  |  |
|--|--|--|--|---|----------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>John W. Sweeney</i> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 19, 1985 |   | 2b. HOUR<br>2:00A.M. |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 31 1924   |                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD. |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2719 Kirkleigh Road |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Foreman   |                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel             |  |

|   |                          |   |   |
|---|--------------------------|---|---|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |                          |   |   |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Baltimore | 13c. CITY OR TOWN<br>Dundalk                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Sweeney                                |                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ethel Currey |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes WW II       |                          | 16b. SOCIAL SECURITY NO.<br>235-30-5101                       |   |
| 17. INFORMANT<br>Mary F. Sweeney  |                          | ADDRESS<br>Same as 13c  |   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pulmonary Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Adeno Carcinoma of the lung</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7/16</i> , 19 <i>85</i> , to <i>7/19</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>7/19</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Charles W. Hoge</i>  |  |  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br><i>7/19/85</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Charles W. Hoge</i>   |  |  |  | 22e. ADDRESS  |  |   |  |

|   |  |                        |  |   |  |  |  |
|---|--|------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>7/22/1985 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, Maryland 21222 |  |                        |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 25 1985            |  |  |  |
|   |  |                        |  | 25. REGISTRAR'S SIGNATURE<br><i>Johanna Davidson</i>    |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on a copy filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

John L. Sweeney

1900-1901

1902

206100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

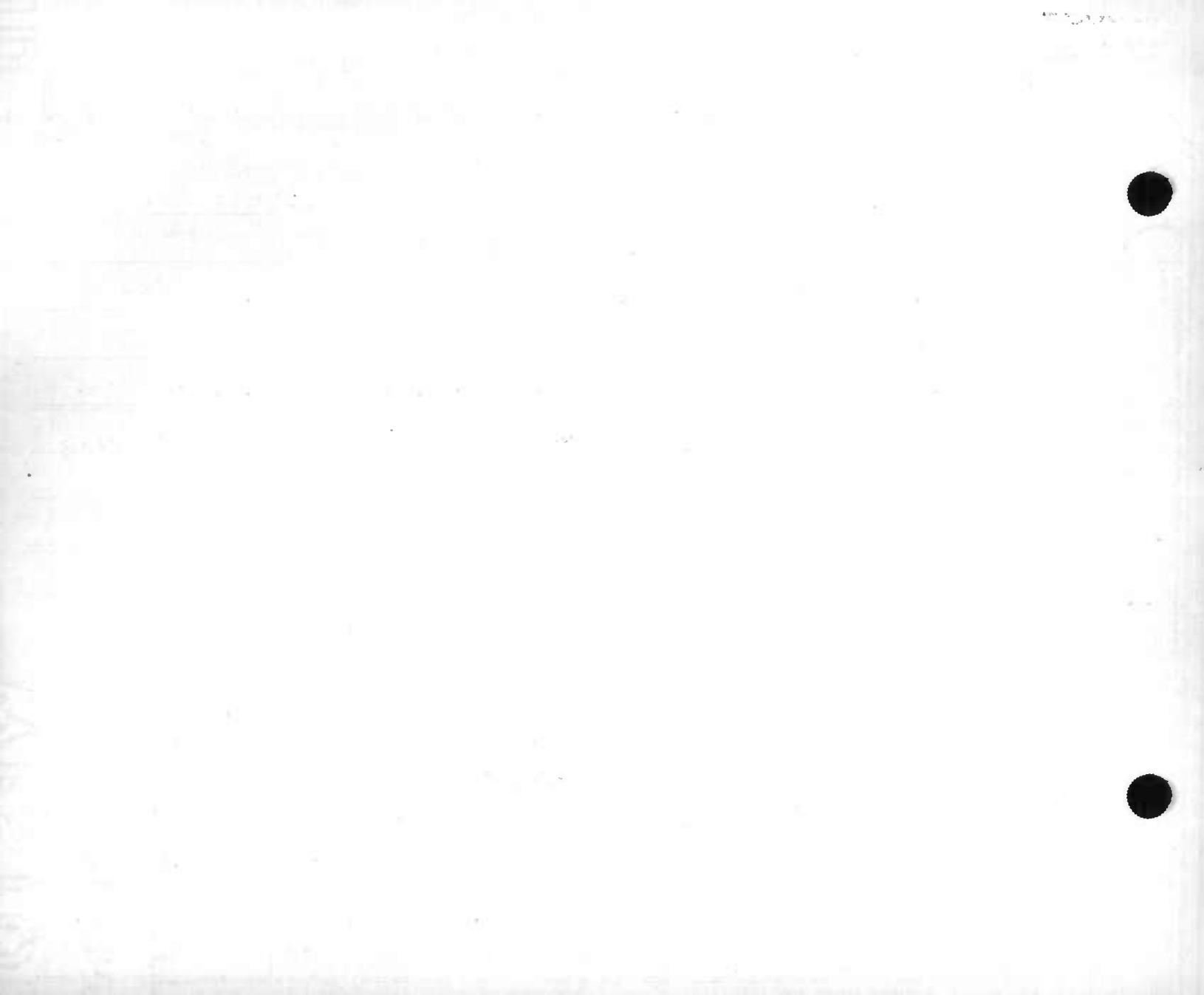
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8518965  |  | REG. NO.  |  | 7  |  | 17 85  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  | MONTH  |  | DAY  |  |
| George A. Sydes  |  |  |  | 7   |  | 17   |  | 85   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                          |  | 7b. HOUR   |  |
| Male   |  | Black  |  | 5 7 1891  |  | 94   |  | M  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |  | 10. USUAL OCCUPATION (TYPE OF WORK, FOR MOST OF WORKING LIFE)  |  |
| Md.  |  | USA  |  |   |  | Baltimore County   |  | Machinist  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK, FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |  |  |
| Towson   |  | 432 E. Pennsylvania Ave  |  |   |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                                 |  | 13e. STREET ADDRESS  |  |
| Md.  |  | Balto.   |  | Towson  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 432 E. Pennsylvania Av   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT  |  |
| Columbus   |  | Mary   |  | No  |  |  |  | Birdie M. Sydes  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anterior sclerotic Heart Disease  |  | 19. DATE OF OPERATION  |  | 19a. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | (b)  |  | (c)   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
|  |  |  |  |   |  |  |  | 4 years  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |  |  |
| 21a. DATE OF OPERATION   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 22a. SIGNATURE   |  | 22b. DATE SIGNED   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. HOUR A.M. MONTH DAY YEAR  |  | 21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 22a. Samuel R. Owings, Jr., M.D.                         |  | 7-18-85  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION   |  | 22c. PHYSICIAN'S NAME (TYPE OR PRINT)                    |  | 22d. ADDRESS   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION   |  | Samuel R. Owings, Jr.                                    |  | 909 N. Carey St. Balto., Md. 21217                             |  |
| 22e. I certify that (1) (this hospital) attended the deceased from Sept. 9, 1981, to July 3, 1985, that (1) (we) last saw the deceased alive on 7-3-85, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  | 23e. DATE REC'D BY REGISTRAR                                   |  |
| Entombment   |  | 7/20/85  |  | Arbutus Mem. Park   |  | Arbutus  |  | JUL 19 1985  |  |
| 24. FUNERAL DIRECTOR   |  | 24a. NAME  |  | 24b. ADDRESS  |  | 24c. REGISTRAR'S SIGNATURE                               |  | 24d. REGISTRAR'S SIGNATURE                                     |  |
| Chatman-Harris   |  | FH 1701  |  | McCulloh Street   |  | JUL 19 1985  |  | JUL 19 1985  |  |

BP

DHMH-16 20M  
(VRA 15, 4) 7/78





REG. NO.

## MEDICAL CERTIFICATION

25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE  
JUL 15 1985

cc:rv

2179

206106

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 18967

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles E. TAYLOR   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 17, 1985  |  | 2b. HOUR<br>2:17 P.M.  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>10 <sup>TH</sup> -4-1914 YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto. County   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cutter   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired   |  |   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY Baltimore 13c. CITY OR TOWN  |  |   |  |   |  |  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  | 13e. STREET ADDRESS / ZIP CODE<br>503 Old Home Rd. 21206  |  |  |  |
| 14. FATHER'S NAME<br>Charles Taylor  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Margaret  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes WW II Army   |  |   |  | 16b. SOCIAL SECURITY NO.<br>215-03-6895   |  |  |  |
| 17. INFORMANT<br>Helen E. Taylor, 503 Old Home Road<br>Baltimore, MD 21206   |  |   |  | ADDRESS   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral Vascular Accident<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Left Atrial Thrombus<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Cardiomegaly  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 11, 1985, to July 17, 1985, that (I) (we) lost<br>saw the deceased alive on July 17, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Linda Villalobos</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>7/17/85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Linda Villalobos, MD  |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>7-20-85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |  | 23d. LOCATION<br>CITY OR TOWN<br>Balto. Balto. MD  |  |
| 24. FUNERAL DIRECTOR<br>John C. Miller, Inc., 6415 Belair Rd.<br>21206   |  |   |  | 25a. DATE REC'D BY REG. 7/23/85<br>25b. REGISTRAR'S SIGNATURE   |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. DECEASED NAME  |  | 2a. DATE OF DEATH  |     | 2b. HOUR   |         |
|---|--|--|-----|--|---------|
| FIRST   | MIDDLE   | MONTH  | DAY | YEAR   |         |
| LEWIS E. THOMAS   |  | 7  | 5   | 85   | 5:50 PM |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   |     | 6. AGE (IN YEARS LAST BIRTHDAY)  |         |
| Male  | White  | MONTH  | DAY | YEAR   | 83      |
|   |  | 11   | 22  | 01   |         |
| 7a. BIRTHPLACE (STATE OR FOREIGN)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |     | 9. BALTIMORE CITY OR COUNTY OF DEATH   |         |
| Illinois  | U.S.A.   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         |     | Baltimore County MD.   |         |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)              |     | 12b. KIND OF BUSINESS OR INDUSTRY  |         |
| Pikesville  | Milford Manor Nursing Home   | Retired  |     | Carpenter  |         |
| 13a. STATE  |  | 13b. COUNTY  |     | 13c. CITY OR TOWN  |         |
| Maryland  |  | Howard   |     | Columbia   |         |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |     | 16. SOCIAL SECURITY NO.  |         |
| David Frederick Thomas  |  | Lydia Tappin   |     | 314 05 2943  |         |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 17b. INFORMANT   |     | 17c. ADDRESS   |         |
| No  |  | David E Thomas   |     | 10117 Wesleigh Dr 21046  |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |     |  |         |
| PART 1. DEATH WAS CAUSED BY:  |  |  |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |         |
| IMMEDIATE CAUSE (a)   |  |  |     | 1 day  |         |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |     | 5 years  |         |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |     | 5-year   |         |
| (b) Arteriosclerotic Heart Disease  |  |  |     |  |         |
| (c) Alzheimer Disease   |  |  |     |  |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |     |  |         |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |     | 20a. AUTOPSY?  |         |
|   |  |  |     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |         |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |         |
|   |  | HOUR A.M. MONTH DAY YEAR   |     |  |         |
|   |  | P.M. 19  |     |  |         |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |     | 21f. LOCATION  |         |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |     | STREET CITY OR TOWN COUNTY STATE   |         |
| 22a. I certify that (I) (this hospital) attended the deceased from July 5, 1985, to July 5, 1985, that (I) (we) lost saw the deceased alive on July 5, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |     |  |         |
| 22b. SIGNATURE  |  |  |     | 22c. DATE SIGNED   |         |
| MANUEL LEVIN M.D.   |  |  |     | 7/5/85   |         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |     | 22e. ADDRESS   |         |
| MANUEL LEVIN M.D.   |  |  |     | 6101 PK HIGGS AVE BALTO MD 21215   |         |
| 23a. BURIAL, CREMATION, REMOVAL (SPPRAX)  |  | 23b. DATE  |     | 23c. NAME OF CEMETERY OR CREMATORY   |         |
| Cremation   |  | July 6, 1985   |     | Westview Memorial Pk   |         |
|   |  |  |     | 23d. LOCATION  |         |
|   |  |  |     | CITY OR TOWN COUNTY STATE  |         |
|   |  |  |     | Catonsville Balto Maryland   |         |
| 24. FUNERAL DIRECTOR  |  |  |     | 25a. DATE REC'D. BY REGISTRAR  |         |
| Harry H Witzke 4112 Columbia Rd Ellicott City   |  |  |     | JUL 9 1985   |         |
|   |  |  |     | 25b. REGISTRAR'S SIGNATURE   |         |
|   |  |  |     |  |         |

BP

601210

THOMAS

1942

11 24 11

*[Faint, mostly illegible handwritten text on lined paper, possibly a letter or report. Some words like "THOMAS" and "1942" are visible.]*



150025

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

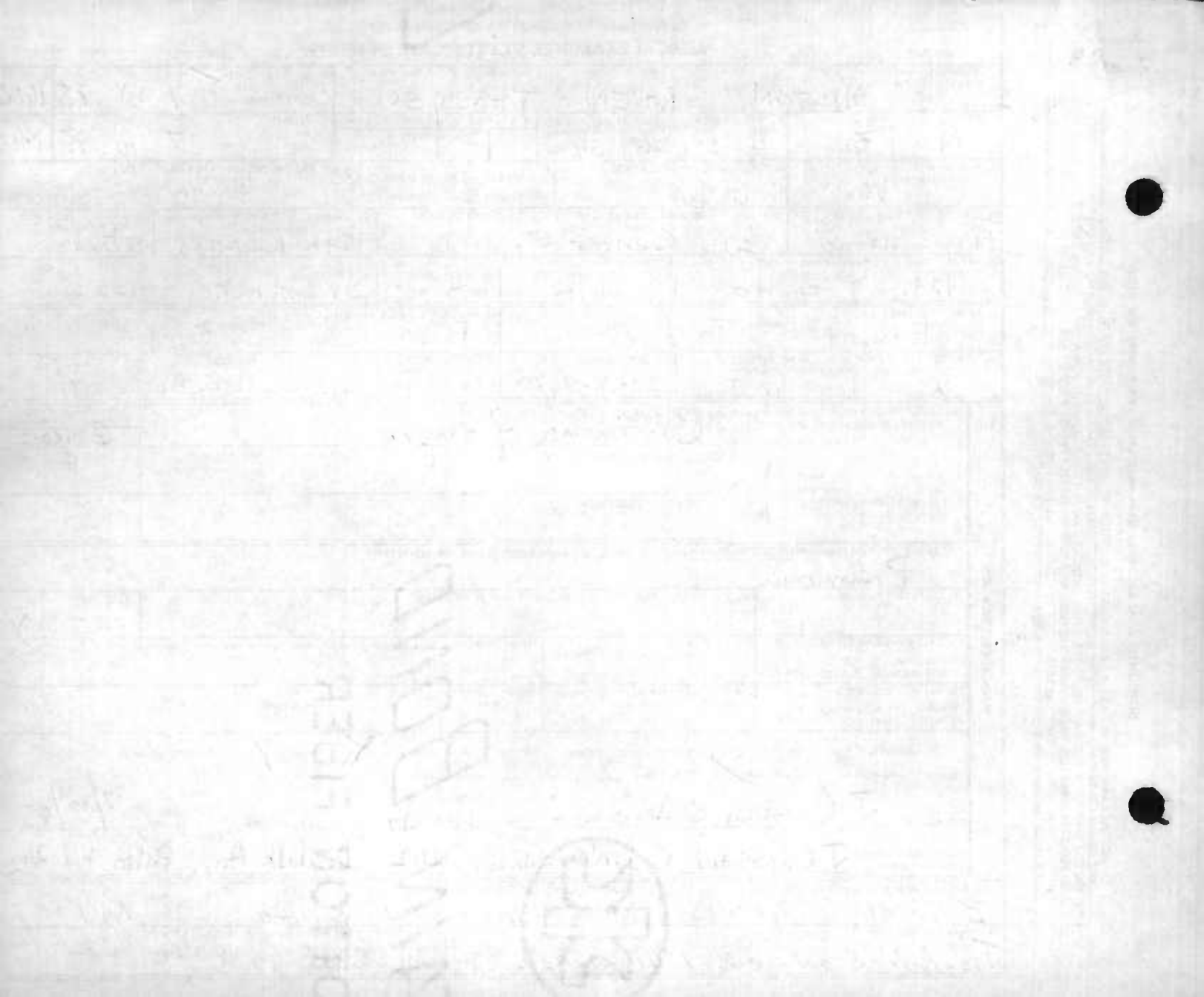
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |              |  |  |   |   |   |  |   |  | REG. NO. 8 9 6 9  |  |
|---|--------------|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MILTON RAVEN THROWER   |              |  |  |   |   |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>7 10 19 85 |  |
| 3. SEX<br>M   | 4. RACE<br>B | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 5 26   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS. | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | 8. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>7 10 19 85  |  | 2d. HOUR<br>1810  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.  |              | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>County of Baltimore                                     |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Turners Station  |              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>219 Center ST. |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bethlehem Steel                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel.   |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |              |  |  |   |   |   |  |   |  |   |  |
| 13a. STATE<br>Md.   |              | 13b. COUNTY<br>Balto   |  | 13c. CITY OR TOWN<br>Dundalk  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>219 Center ST. 21222   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edmond Thrower  |              |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pearl Byrd   |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes  |              |  |  | 16b. SOCIAL SECURITY NO.<br>WWII 220-18-7630  |   | 17. INFORMANT<br>ADDRESS<br>Dorothy Jones-2636 E. Biddle ST. 21213                              |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line. For (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of larynx</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 years                                     |              |  |  |   |   |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><u>Pneumonia</u>  |              |  |  |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |              |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |              |  |  |   |   |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>J. Crossan O'Donovan  |              |  |  | TITLE (SPECIFY)<br>M.D. Deputy  |   | MEDICAL EXAMINER  |  | DATE SIGNED<br>7/10/85  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>J. CROSSAN O'DONOVAN  |              |  |  | ADDRESS<br>2112 Dundalk Ave., Balto, Md. 21222  |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(YES-IF)   |              | 23b. DATE<br>7/13/85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. CALVARY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto Md.   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Jas. A. MORTON & Sons   |              |  |  | ADDRESS<br>1701 Laurens ST.   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 12 1985  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall                                 |  |   |  |







07/84  
25M

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR AT5 ME (5))

|   |  |  |  |  |  |  |  |                                    |  |                                    |  |                                |  |          |  |
|---|--|--|--|--|--|--|--|------------------------------------|--|------------------------------------|--|--------------------------------|--|----------|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH    |  |  |  |  |  | REG. NO. 8970                      |  |                                    |  |                                |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2. DATE KNOWN<br>OF ESTI-<br>MATED |  | 3. MONTH DAY YEAR                  |  | 4. HOUR                        |  |          |  |
| ANNE LOUISE TOMSHACK  |  |  |  |  |  |  |  | 7-29-85                            |  | 19                                 |  | M                              |  |          |  |
| 5. SEX  |  | 6. RACE  |  | 7. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 8. AGE (IN YEARS<br>LAST BIRTHDAY)   |  | 9. IF UNDER 1 YR.<br>MONTHS DAYS   |  | 10. IF UNDER 24 HRS.<br>HOURS MIN. |  | 11. DATE<br>PRONOUNCED<br>DEAD |  | 12. HOUR |  |
| Female  |  | White  |  | April 7 1931   |  | 54 YRS.  |  |                                    |  |                                    |  | 7-29-85                        |  | 6:35A    |  |
| 13. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |  | 14. CITIZEN OF WHAT COUNTRY?   |  | 15. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 16. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                    |  |                                    |  |                                |  |          |  |
| Pennsylvania  |  | U. S. A.   |  |  |  | Baltimore County   |  |                                    |  |                                    |  |                                |  |          |  |
| 17. CITY OR TOWN OF DEATH   |  | 18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 19. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 20. KIND OF BUSINESS<br>OR INDUSTRY  |  |                                    |  |                                    |  |                                |  |          |  |
| Lansdowne   |  | 2212 Smith Avenue  |  | Homemaker  |  |  |  |                                    |  |                                    |  |                                |  |          |  |
| 21. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 22. STATE  |  | 23. CITY OR TOWN   |  | 24. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 25. STREET ADDRESS                 |  |                                    |  |                                |  |          |  |
| Maryland  |  | Baltimore  |  | Lansdowne  |  | XX   |  | 2212 Smith Avenue                  |  | 21227                              |  |                                |  |          |  |
| 26. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 27. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  | 28. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  | 29. SOCIAL SECURITY NO.  |  | 30. INFORMANT                      |  | 31. ADDRESS                        |  |                                |  |          |  |
| Pasquale  |  | Variati  |  |  |  | 194-24-9707  |  | Joseph Thomshack                   |  | 2212 Smith Avenue                  |  | 21227                          |  |          |  |
| 32. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  | 33. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |  |  |  |  |                                    |  |                                    |  |                                |  |          |  |
| 34. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |                                    |  |                                    |  |                                |  |          |  |
| 35. DATE OF OPERATION   |  | 36. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 37. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |                                    |  |                                    |  |                                |  |          |  |
| 38. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 39. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 40. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |                                    |  |                                    |  |                                |  |          |  |
| 41. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 42. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  | 43. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |                                    |  |                                    |  |                                |  |          |  |
| 44. 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 45. ACTUAL<br>SIGNATURE <i>Margaret A. Korell</i>  |  | 46. TITLE (SPECIFY)<br>Assistant   |  | 47. DATE<br>SIGNED 7-29-85   |  |                                    |  |                                    |  |                                |  |          |  |
| 48. EXAMINER'S NAME<br>(TYPE OR PRINT)  |  | 49. ADDRESS  |  | 50. MEDICAL EXAMINER   |  |  |  |                                    |  |                                    |  |                                |  |          |  |
| Margarita A. Korell, M.D.   |  | 111 Penn Street  |  |  |  |  |  |                                    |  |                                    |  |                                |  |          |  |
| 51. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 52. DATE   |  | 53. NAME OF CEMETERY OR CREMATORY  |  | 54. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |                                    |  |                                    |  |                                |  |          |  |
| Burial  |  | August 1 1985  |  | Meadowridge Mem. Park  |  | Elkridge   |  | Howard                             |  | Maryland                           |  |                                |  |          |  |
| 55. FUNERAL DIRECTOR<br>NAME ADDRESS  |  | 56. DATE REC'D. BY REGISTRAR   |  | 57. REGISTRAR'S SIGNATURE  |  |  |  |                                    |  |                                    |  |                                |  |          |  |
| Hubbard Funeral Home, Inc. 4107 Wilkens Avenue  |  | JUL 31 1985  |  | <i>She Davidson-Randall</i>  |  |  |  |                                    |  |                                    |  |                                |  |          |  |

90412

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

190141

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH85 18971  
REG. NO.

|   |  |  |   |   |  |  |   |  |   |  |  |
|---|--|--|---|---|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Vera A. Turck</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 1, 1985</b>                    |   |  | 2b. HOUR<br><b>11:28 AM</b>  |   |  |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 20 1918</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Essex</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2162 Vailthorn Rd. 21220</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214/26/8656</b> |   | 17. INFORMANT<br>ADDRESS<br><b>William E. Turck (son) same as 13e.</b>         |  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Pulmonary Embolus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |   |   |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 26, 1985</b> to <b>July 1, 1985</b> , that (I) (we) last saw the deceased alive on <b>July 1, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |  |   |   |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i><br>DEGREE  |  |  |   |   |  | 22c. DATE SIGNED<br><b>7-1-85</b>  |   |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Linda Villalobos M.D.</b>   |  |  |   |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>                               |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |  | 23b. DATE<br><b>7/2/1985</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cemetery</b>              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Walter Brooks Bradley Inc. Balto., Md. 21222</b>   |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 03 1985</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |  |  |

MEDICAL CERTIFICATION



2020 COLUMBIA  
FIBER  
PLOW

211088

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 18972

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 7-22-1985   |  | 1:45 PM   |  |
| George Robert Turner   |  |  |  |   |  |   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Male   |  | Black  |  | MONTH DAY YEAR<br>5 9 1889  |  | 96 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Maryland   |  | U. S. A.   |  |   |  | Baltimore County MD.  |  |
| 11. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore  |  | Baltimore County General Hospital  |  | Maintenance Worker  |  | Can Company   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS / ZIP CODE  |  | 3413 Mondawmin Ave. Baltimore, Maryland 21216                       |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |   |  |   |  |
| John Turner  |  | Unknown Unknown  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | 6914 Digby Road Baltimore, Maryland 21207                           |  |
| No.  |  | 218-10-9150  |  | Irma T. Parham  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Left lower lobe pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dehydration, malnutrition</u> |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Allen J. Edwards M.D.</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Allen J. Edwards M.D.</u>  |  |  |  | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| Burial   |  | 7/27/1985  |  | Arbutus Memorial Park   |  | Baltimore, Maryland   |  |
| 24. FUNERAL HOME OR OTHER PERSON TO WHOM BODY WAS DELIVERED<br>NAME ADDRESS<br>Nutter & Sons Funeral Home, Inc. 21216<br>2501 Gwynns Falls Pkwy. Baltimore, Maryland   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>25b. REGISTRAR'S SIGNATURE<br>JUL 26 1985 <u>Richard R. Riddle</u>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

111032

10/1/50

Black 2 3 1860

Male

Female

Admission

Admission

Admission

210-10-1150

No.

Witten & Sons Funeral Home, Inc.  
2501 Thynne Falls Road, Baltimore, Maryland  
21215  
Baltimore, Maryland

212029

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 2 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. IF THE MEDICAL EXAMINER IS UNAVAILABLE, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AT THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8973

1. FOR  
STATE  
REGISTRAR

|   |         |                                    |  |  |                                    |   |  |   |                                      |  |  |
|---|---------|------------------------------------|--|--|------------------------------------|---|--|---|--------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |                                    | FIRST MIDDLE LAST  |  |                                    | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED   |  |   | MONTH DAY YEAR                       |  |  |
| MARCELLUS H. UHLER (JR.)  |         |                                    |  |  |                                    | JULY 26 1985  |  |   | P.M.                                 |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR | 6. AGE (IN YEARS<br>LAST BIRTHDAY)   | IF UNDER 1 YR.<br>MONTHS DAYS                                  | IF UNDER 24 HRS.<br>HOURS MIN      | 2c. DATE<br>PRONOUNCED<br>DEAD  |  |   | MONTH DAY YEAR                       |  |  |
| MALE  | WHITE   | 02 17 30                           | 55 RS.   |  |                                    | JULY 26 1985  |  |   | P.M.                                 |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         |                                    | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |
| MD  |         |                                    | USA  |  |                                    |   |  |   | BALTIMORE COUNTY MD.                 |  |  |
| 10. CITY OR TOWN OF DEATH   |         |                                    | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  |   | 12b. KIND OF BUSINESS<br>OR INDUSTRY |  |  |
| TOWSON  |         |                                    | ST JOSEPHS HOSPITAL  |  |                                    | Mechanical Eng.   |  |   | Gas & Elec.                          |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |         |                                    |  |  |                                    |   |  |   |                                      |  |  |
| 13a. STATE  |         | 13b. CITY                          |  | 13c. CITY OR TOWN  |                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS   |                                      |  |  |
| MD  |         | BALTIMORE                          |  | TOWSON   |                                    |   |  | 7 ACORN CIRCLE  |                                      |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |         |                                    |  |  |                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |                                      |  |  |
| Marcellus H. Uhler, Sr.   |         |                                    |  |  |                                    | Erma Hemphill   |  |   |                                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         |                                    |  | 16b. SOCIAL SECURITY NO.                                       |                                    | 17. INFORMANT ADDRESS   |  |   |                                      |  |  |
| Yes   |         |                                    |  | Korean   |                                    | 213-26-3339 Barbara E. Uhler; 2125 Fountain Hill Dr. 21093  |  |   |                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |                                    |  |  |                                    |   |  |   |                                      |  |  |
| PART I DEATH WAS CAUSED BY:   |         |                                    |  |  |                                    |   |  |   |                                      |  |  |
| IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u>  |         |                                    |  |  |                                    |   |  |   |                                      |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                                    |  |  |                                    |   |  |   |                                      |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:   |         |                                    |  |  |                                    |   |  |   |                                      |  |  |
| (b) <u></u>   |         |                                    |  |  |                                    |   |  |   |                                      |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                                    |  |  |                                    |   |  |   |                                      |  |  |
| (c) <u></u>   |         |                                    |  |  |                                    |   |  |   |                                      |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |         |                                    |  |  |                                    |   |  |   |                                      |  |  |
| 19a. DATE OF OPERATION  |         |                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |                                    |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19     |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |                                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         |                                    |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.) |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                      |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                                    |  |  |                                    |   |  |   |                                      |  |  |
| ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>  |         |                                    |  |  |                                    | MEDICAL EXAMINER  |  |   | DATE SIGNED <u>7/26/85</u>           |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         |                                    |  |  |                                    | ADDRESS   |  |   |                                      |  |  |
| Charles F. O'Donnell  |         |                                    |  |  |                                    | 7501 York Rd.; Towson, MD 21204   |  |   |                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         |                                    | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |                                      |  |  |
| Burial  |         |                                    | 07-30-85   |  | Woodlawn Cemetery                  |   |  | Woodlawn Baltimore MD   |                                      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |         |                                    |  |  |                                    | 25a. DATE REC'D. BY REGISTRAR   |  |   | 25b. REGISTRAR'S SIGNATURE           |  |  |
| Hubbard Funeral Home; 4107 Wilkens Ave. 21229   |         |                                    |  |  |                                    | JUL 29 1985   |  |   | <u>Charles F. O'Donnell</u>          |  |  |

1130X

RECEIVED

NO 10 30 32

WHITE NO 10

1130X

RECEIVED

BALTIMORE COUNTY

ST. JOHN'S

1130X

RECEIVED

BALTIMORE COUNTY



1130X

1130X





BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |   |  |  |   |  |
|---|--|--|---|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   | REG. NO. 85 18974   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>FRANCIS T. USILTON   |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>07 17 '85                   |  |  | 2b. HOUR MIN<br>2:45P M   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>2/15/11  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                     |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREATER BALTIMORE MEDICAL CENTER |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Conductor     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Railroad   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE COUNTY<br>Maryland - -   |  |  |   |   | 13b. CITY OR TOWN<br>Baltimore                                  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George T. Usilton  |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Helen E. Thompson |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>- -  |   | 17. INFORMANT ADDRESS<br>21204 Suite #402, Towson, Md.<br>305 W. Chesapeake Ave.  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) METASTATIC CARCINOMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) PANCREATIC CARCINOMA<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MINUTES<br>MONTHS<br>MONTHS |  |  |   |   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) this hospital attended the deceased from 7/7 1985 to 7/17 1985 that (I) (we) last saw the deceased alive on 7/17 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.  |  |  |   |   |   |  |  |   |  |
| 22b. SIGNATURE<br>Anne W. Wernicki  |  |  |   |   | DEGREE<br>M.D.  |  |  | 22c. DATE SIGNED<br>7-17-85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. J. WERNICKI  |  |  |   |   | 22e. ADDRESS<br>GBMC - 6701 N. CHARLES STREET 21204             |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>7/19/85  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Pk               |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto, Md.  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Schimunek Funeral Home, Balto, Md. 21213   |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 19 1985                    |  | 25b. REGISTRAR'S SIGNATURE<br>John A. Borden   |   |  |

[illegible]

2. 11. 1951

210176

FOR  
1- STATE  
REGISTRAR

JAMES J.  
VELENOVSKY

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 18975

|  |  |   |  |  |                                |  |
|--|--|---|--|--|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Jamar J. Velenovsky</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>July 23 1985</i> |  | 2b. HOUR<br>M<br><i>5:50 P</i> |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>11 27 1898</i>  |                                |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>86</b><br>YRS. MONTHS DAYS<br>IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN. |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson MD</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Hosp</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto Co.</b> MD  |                                |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>COUNTY CLERK</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PERMITS</b>   |  | 13. STREET ADDRESS / ZIP CODE<br><b>8047 PHILADELPHIA RD 21237</b>   |                                |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>ROSEDALE</b>   |                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WENCESLAUS --- VELENOVSKY</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA --- VALIS</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO N/A</b>        |                                |  |
| 16b. SOCIAL SECURITY NO.<br><b>216169420</b>   |  | 17. INFORMANT<br><b>DOROTHY VELENOVSKY</b>  |  | ADDRESS<br><b>8047 PHILADELPHIA RD 21237</b>   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic C.V. Dis</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Renal Insufficiency &amp; Cirrhosis of Liver</i><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Renal Insufficiency &amp; Cirrhosis of Liver</i> |  |   |  |  |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |                                |  |
| 22b. SIGNATURE<br><i>Lester A. Wall Jr</i> MD  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><i>7/23/85</i>   |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LESTER A. WALL JR MD</b>   |  | 22e. ADDRESS<br><b>7620 York Rd Towson MD 21204</b>   |  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>7/25/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS of FAITH</b>  |                                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO BALTO MD</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>JUL 25 1985</b>   |  | 23f. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Gregory E. Smith</i> ADDRESS<br><b>1211 Chesaco Ave</b>   |  |   |  |  |                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

20% COTTON FIBER

CHIEF WALKER BOWMAN



207176

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85

18976

1 8 9

REG. NO.

|   |  |  |  |   |   |  |   |  |  |
|---|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET C. VOGEL</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>22</b> YEAR <b>85</b>  |   |  |   | 2b. HOUR<br><b>11:50 AM</b>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>24</b> YEAR <b>23</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <b>61</b> DAYS <b>11</b> HOURS <b>50</b> MIN.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CO. MD.</b>   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>STELLA MARIS HOSPICE</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALES LADY</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DEPT. STORE</b>  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |   |  |   |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>5910 GRACE AVE 21206</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>GEORGE</b> MIDDLE <b>A</b> LAST <b>CHALMERS</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b>C</b> LAST <b>FREY</b>  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>217-16-8774</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Joseph J. Vogel Jr. 5910 GRACE AVE.</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC BREAST CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a |  |  |  |   |   |  |   |  |  |
| MEDICAL CERTIFICATION   |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7.19</b> 19 <b>85</b> , to <b>7.22</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>7.22</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>K R Faulkner MD</b>  |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>7.22.85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kendall R. Faulkner, M.D.</b>   |  |  |  |   |   | 22e. ADDRESS<br><b>Stella Maris Hospice<br/>2300 Dulany Valley Rd. - Towson, MD 21204</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>JULY 25, 1985</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARRISON FOREST YET.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>OWINGS MILLS BALTO. MD</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HARTLEY Miller</b>   |  |  |  |   |   | ADDRESS<br><b>7527 HARTFORD Rd</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 24 1985</b>  |  |
|   |  |  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |   |  |  |

BP

1. The first part of the report is a general introduction to the project. It describes the purpose of the study and the objectives that were set at the beginning. It also mentions the scope of the work and the limitations of the study.

2. The second part of the report is a detailed description of the methodology used in the study. It explains the research design, the data collection methods, and the analysis techniques that were employed. This section is crucial for understanding how the results were obtained and for assessing the reliability of the findings.

3. The third part of the report presents the results of the study. It includes a summary of the findings, as well as a more detailed discussion of the data. This section is where the researcher shares the outcomes of the investigation and discusses their implications for the field of study.

4. The fourth part of the report is a conclusion and a discussion of the findings. It summarizes the main points of the study and discusses the implications of the results. This section also includes a reflection on the strengths and weaknesses of the study and suggestions for future research.

5. The final part of the report is a list of references. It includes all the sources that were consulted during the research process. This section is important for providing context for the study and for allowing other researchers to locate the original sources of the information used in the report.

|   |  |         |  |  |  |                   |  |  |  |                  |  |  |  |             |  |   |  |  |  |
|---|--|---------|--|--|--|-------------------|--|--|--|------------------|--|--|--|-------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  | LAST              |  | 20. DATE KNOWN<br>OF DEATH   |  | 21. MONTH        |  | 22. DAY  |  | 23. YEAR    |  | 24. HOUR  |  |  |  |
| CHARLES   |  |         |  |  |  | WAECHTER, JR.     |  | JULY 4 1985  |  | JULY 4 1985      |  | JULY 4 1985  |  | JULY 4 1985 |  | JULY 4 1985   |  |  |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS) |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS. |  | 7c. DATE   |  | 7d. HOUR    |  | 7e. MIN.  |  |  |  |
| M   |  | W       |  | 10 15 26   |  | 58 YRS.           |  | MONTHS   |  | DAYS             |  | HOURS  |  | MIN.        |  | DEAD  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |  |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |             |  | 10. BALTIMORE CO.   |  |  |  |
| MARYLAND  |  |         |  | U.S.A.   |  |                   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |                  |  | BALTIMORE CO.  |  |             |  | MD.   |  |  |  |
| 11. CITY OR TOWN OF DEATH   |  |         |  | 12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  |                   |  | 13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                  |  | 13b. KIND OF BUSINESS OR INDUSTRY  |  |             |  | 14. BALTIMORE CO.   |  |  |  |
| TOWSON  |  |         |  | GREATER BALTIMORE MEDICAL CENTER   |  |                   |  | SECURITY ADVISOR   |  |                  |  | GOVT.  |  |             |  | BALTIMORE CO.   |  |  |  |
| 15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                      |  |         |  | 16a. STATE   |  |                   |  | 16b. COUNTY  |  |                  |  | 16c. CITY OR TOWN  |  |             |  | 16d. INSIDE CITY LIMITS?  |  |  |  |
| MARYLAND  |  |         |  | BALTIMORE  |  |                   |  | 21204  |  |                  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |             |  | 16e. STREET ADDRESS   |  |  |  |
| 17. FATHER'S NAME   |  |         |  | 18. MOTHER'S MAIDEN NAME   |  |                   |  | 19. FATHER'S NAME  |  |                  |  | 20. MOTHER'S MAIDEN NAME   |  |             |  | 21. FATHER'S NAME   |  |  |  |
| CHARLES   |  |         |  | WAECHTER, SR.  |  |                   |  | CHARLOTTE  |  |                  |  | DORSCH   |  |             |  | DORSCH  |  |  |  |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |         |  | 23. SOCIAL SECURITY NO.  |  |                   |  | 24. INFORMANT  |  |                  |  | 25. ADDRESS  |  |             |  | 26. ADDRESS   |  |  |  |
| YES   |  |         |  | 1943-1963  |  |                   |  | 214-20-2919  |  |                  |  | CHERIE L. WAECHTER TOWSON, MD  |  |             |  | 21204   |  |  |  |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |  | 18. PART I DEATH WAS CAUSED BY:  |  |                   |  | 19. IMMEDIATE CAUSE (a)  |  |                  |  | 20. DUE TO, OR AS A CONSEQUENCE OF   |  |             |  | 21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |  |         |  | (b)  |  |                   |  | (c)  |  |                  |  | (d)  |  |             |  | (e)   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |         |  | 22. DATE OF OPERATION  |  |                   |  | 23. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                  |  | 24. AUTOPSY?   |  |             |  | 25. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 26. EXTERNAL CAUSE WAS  |  |         |  | 27. TIME OF INJURY   |  |                   |  | 28. HOW INJURY OCCURRED  |  |                  |  | 29. ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2   |  |             |  | 30. CITY OR TOWN  |  |  |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |  | P.M.   |  |                   |  | 19   |  |                  |  | 21. LOCATION   |  |             |  | 22. COUNTY  |  |  |  |
| 31. INJURY OCCURRED   |  |         |  | 32. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                   |  | 33. LOCATION   |  |                  |  | 34. CITY OR TOWN   |  |             |  | 35. COUNTY  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |         |  | 36. I certify that I took charge of the remains described above, held on   |  |                   |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                  |  | 37. DATE   |  |             |  | 38. SIGNED  |  |  |  |
| 39. death resulted from:  |  |         |  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                   |  | 39. I certify that I took charge of the remains described above, held on   |  |                  |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |             |  | 37. DATE  |  |  |  |
| 40. ACTUAL SIGNATURE  |  |         |  | 41. EXAMINER'S NAME  |  |                   |  | 42. ADDRESS  |  |                  |  | 43. MEDICAL EXAMINER   |  |             |  | 44. DATE SIGNED   |  |  |  |
| CHARLES O'DONNELL   |  |         |  | JULY 8, '85  |  |                   |  | DULANEY VALLEY MEM. GAR. BALTIMORE CO., MD   |  |                  |  | JULY 8, '85  |  |             |  | JULY 8, '85   |  |  |  |
| 45. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 46. DATE   |  |                   |  | 47. NAME OF CEMETERY OR CREMATORY  |  |                  |  | 48. LOCATION   |  |             |  | 49. COUNTY  |  |  |  |
| BURIAL  |  |         |  | JULY 8, '85  |  |                   |  | DULANEY VALLEY MEM. GAR. BALTIMORE CO., MD   |  |                  |  | JULY 8, '85  |  |             |  | JULY 8, '85   |  |  |  |
| 50. FUNERAL DIRECTOR  |  |         |  | 51. NAME   |  |                   |  | 52. ADDRESS  |  |                  |  | 53. DATE REC'D. BY REGISTRAR   |  |             |  | 54. REGISTRAR'S SIGNATURE   |  |  |  |
| WILLIAM E. JOHNSON  |  |         |  | 8521 LOCH RAVEN BLVD   |  |                   |  | JULY 05 1985   |  |                  |  | JULY 05 1985   |  |             |  | JULY 05 1985  |  |  |  |



2

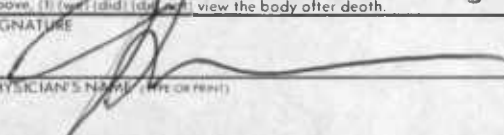
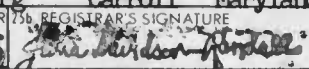


150057

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 18978

1- FOR Film G608 item 16a  
STATE REGISTRAR 10/7/85 rja

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mr. Paul R. Walke</b>  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 9 1985</b>  |  | 2b HOUR<br>M<br><b>AM</b>  |  |
| 3 SEX<br><b>Male</b>  | 4 RACE<br><b>Caucasian</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 29 1922</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8 MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Randallstown</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3801 Lumo Rd.</b> |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Civil Service</b>                                      |
| 13a STATE<br><b>Maryland</b>  |   | 13b COUNTY<br><b>Baltimore</b>  | 13c CITY OR TOWN<br><b>Randallstown</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul Walke</b>  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mrs. Mary Alice Walke</b>  |  | 13e STREET ADDRESS / ZIP CODE<br><b>3801 Lumo Rd. 21133</b>  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>072-16-6514</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Mrs. Mary Alice Walke 21133</b><br><b>3801 Lumo Rd. Randallstown, Maryland</b>       |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetic mellitus</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>  |   |   |  |  |  |
| 19a DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>6-13 1985</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-13 1985</b> to <b>6-18 1985</b> , that (I) (we) last saw the deceased alive on <b>6-18 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE<br>   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>      |  | 22c. DATE SIGNED<br><b>7/10/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul Walke</b>  |   | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>7-11-85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Park</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Eldersburg Carroll Maryland</b>  |   | 23e. DATE REC'D. BY REGISTRAR<br><b>JUL 12 1985</b>   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>  |   | 24b. ADDRESS<br><b>8728 Liberty Road Randallstown, Maryland 21133</b>   |  | 25. REGISTRAR'S SIGNATURE<br> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 85 18979

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  | 1 DECEASED NAME (TYPE OR PRINT) <b>Allan C. WALKER</b>                              |  | 2a DATE OF DEATH MONTH DAY YEAR <b>July 5, 1985</b>  |  | 2b HOUR <b>6:30 p.m.</b>  |  |
| 3 SEX <b>Male</b>   |  | 4 RACE <b>White</b>   |  | 5 DATE OF BIRTH <b>March 13 1905</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b>  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH <b>Rossville 21237</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Franklin Sq. Hospital</b> |  | 12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Examiner</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY <b>U.S. Customs</b>  |  |
| 13a STATE <b>Maryland</b>   |  |   |  | 13b CITY OR TOWN <b>Baltimore</b>  |  | 13c CITY OR TOWN <b>Essex</b>   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Harriet Walker</b>  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b SOCIAL SECURITY NO. <b>216 44 7018</b>  |  | 17 INFORMANT ADDRESS <b>Helen C. Walker, Wife Same</b>   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b>   |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |   |  |
| (c)   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>  |  |   |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                     |  | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>                          |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 2, 1985</b> to <b>July 5, 1985</b> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>July 5, 1985</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |  |  |  |   |  |
| 22b SIGNATURE <b>Gary Johnson</b>   |  |   |  | DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                            |  | 22c DATE SIGNED <b>7/5/85</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gary Johnson</b>  |  |   |  | 22e ADDRESS <b>156 Lionel St Balt MD Franklin Sq Hosp.</b>   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b DATE <b>7/9/85</b>  |  | 23c NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>   |  | 23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>  |  |
| 24 FUNERAL DIRECTOR <b>Brodzinski Funeral Home</b>  |  |   |  | 25a DATE REC'D BY REGISTRAR <b>JUL 09 1985</b>   |  | 25b REGISTRAR'S SIGNATURE <b>G. Anderson-Ward</b>   |  |

5902

203147

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 1 8 9 8 0

|  |  |   |   |   |                             |   |  |
|--|--|---|---|---|-----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SARAH E. WALLACE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7-03-85</b> |   | 2b. HOUR<br><b>12:20 AM</b> |   |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>B</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 28 04</b>  |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN<br><b>81 YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pt. of Rock's</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |                             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Frederick</b>   |   | 13c. CITY OR TOWN<br><b>Pt. of Rocks</b>  |                             | 13d. STREET ADDRESS / ZIP CODE<br><b>unknown 21777 Md.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Henry Frazier</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha Jane McCubbins</b>   |   |   |                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><b>213-62-8975</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Frederick, Maryland 21701<br/>Katherine Spense P.O. Box 272</b>  |                             |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>STROKE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>BRAIN TUMOR</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |   |   |                             | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                             | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                             |   |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |                             |   |  |
| 22b. SIGNATURE<br><b>RUPAK C. MITRA</b>  |  |   |   | DEGREE<br><b>MD</b>   |                             | 22c. DATE SIGNED<br><b>7/3/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RUPAK C. MITRA</b>   |  |   |   | 22e. ADDRESS  |                             |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>7-4-85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Smithsburg Crematory</b>   |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Smithsburg Wash. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>G. Douglas Stauffer</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>10 10 1985</b>  |                             | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |
| 1621 Opossumtown Pk. Frederick, Md. 21701  |  |   |   |   |                             |   |  |

MEDICAL CERTIFICATION

1944-22-26-7

WARRIOR 2 44742

1944-22-26-7 1944-22-26-7 1944-22-26-7

1944-22-26-7

1944-22-26-7

1944-22-26-7

RECEIVED

1944-22-26-7

1944-22-26-7

1944-22-26-7



159065

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 85 18981

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |  |
|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM LLOYD WALLACE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 9, 1985</b>                               |  | 2b. HOUR<br><b>3:16p M</b>   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 5 1899</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self-Employed</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Civil Engr.</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Cockeysville</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Frederick Wallace</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Estelle G. Peterson</b>              |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>  | 17. INFORMANT<br>ADDRESS<br><b>Ruth C. Wallace, 608 Knollcrest Pl., 21030</b>   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Left pyelonephritis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Left ureteral obstruction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <b>Carcinoma of bladder</b> |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Carcinoma of the lung</b>   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 8, 1985</b> , to <b>July 9, 1985</b> , that (I) (we) last saw the deceased alive on <b>July 9, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                    |  |   |  |  |  |  |
| 22b. SIGNATURE<br><i>Robert A. Palermo</i>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7/10/85</b>           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert A. Palermo, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>6701 N. Charles St. Balto., MD 21204</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>7/12/85</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville Baltimore Md.</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Bryan W. Clary, 10 W. Padonia Rd., 21093</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 12 1985</b>  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Carla Davidson-Randall</i>  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

100-100000

1. Name: [illegible]  
2. Address: [illegible]  
3. City: [illegible]  
4. State: [illegible]  
5. Zip: [illegible]  
6. Date: [illegible]  
7. Signature: [illegible]  
8. Title: [illegible]  
9. Phone: [illegible]  
10. Fax: [illegible]  
11. E-mail: [illegible]  
12. Other: [illegible]

1. Name: [illegible]  
2. Address: [illegible]  
3. City: [illegible]  
4. State: [illegible]  
5. Zip: [illegible]  
6. Date: [illegible]  
7. Signature: [illegible]  
8. Title: [illegible]  
9. Phone: [illegible]  
10. Fax: [illegible]  
11. E-mail: [illegible]  
12. Other: [illegible]



203428

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 9 8 2  
REG. NO.1- FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARY K WALSH</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>07-15-85</b>  |  | 2b. HOUR<br><b>01:25 AM</b>  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>08-08-30</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b>   | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Reisterstown</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <b>607 Sherley Manor Rd. 21136</b> |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George J Woytowicz</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Eva Kief</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  | 16b. SOCIAL SECURITY NO.<br><b>219-28-0109</b>   | 17. INFORMANT ADDRESS<br><b>Maynard Walsh Sherley Manor rd. 607 Reisterstown Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE BREAST WITH</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>WIDESPREAD METASTASIS.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>SEPSIS.</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>D.I.C.</b><br>(c) _____ |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>07/09</b> , 19 <b>85</b> , to <b>07/15</b> , 19 <b>85</b> , that (I) (we) lost<br>saw the deceased alive on <b>07/15</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Kaushalendra K. Singh</b>   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7/15/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KAUSHALENDRA K. SINGH</b>  |  | 22e. ADDRESS <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>7-18-1985</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garden of Faith</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Balti. Md.</b>               |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Eline Funeral Home</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JUL 16 1985 J</b>   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with a 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

222111-110110-110110



110110-110110-110110

152087

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC NO 8 9 8 3

|   |   |  |  |  |                               |
|---|---|--|--|--|-------------------------------|
| 1. FOR STATE REGISTRAR  |   | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR   |                               |
| 1. DECEASED NAME (TYPE OR PRINT)  |   | 2c. DATE PRONOUNCED DEAD   |  | 2d. HOUR   |                               |
| FIRST MIDDLE LAST   |   | MONTH DAY YEAR   |  | MONTH DAY YEAR   |                               |
| BLAIN Albert WALTER, Sr.  |   | 7 11 1985  |  | 5:50 P.M.  |                               |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH (MONTH DAY YEAR)  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.   | 7. IF UNDER 1 YR. MONTHS DAYS  | 8. IF UNDER 24 HRS. HOURS MIN |
| Male  | White   | Feb. 15 1910   | 75   |  |                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                               |
| Lewistown, Pa.  | USA   |  |  | Baltimore County MD.   |                               |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                              |                               |
| Middle River 21220  | 9902-E Tailspin Lane  |  |  | Carpenter  |                               |
| 12b. KIND OF BUSINESS OR INDUSTRY   | Construction  |  |  |  |                               |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS  |                               |
| Maryland  | Baltimore   | Middle River   |  | 9902 "E" Tailspin Lane 21220   |                               |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)   |   | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)   |  |  |                               |
| James Walter  |   | Cora Mattern   |  |  |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |                               |
| No  |   | 174 18 0296  |  | Dorothy R. Walter, Wife Same   |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |  |  |  |                               |
| PART I DEATH WAS CAUSED BY:   |   |  |  |  |                               |
| IMMEDIATE CAUSE (a) <u>Gunshot wound of head (rifle)</u>  |   |  |  |  |                               |
| DUE TO, OR AS A CONSEQUENCE OF  |   |  |  |  |                               |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |   |  |  |  |                               |
| (b) _____ DUE TO, OR AS A CONSEQUENCE OF  |   |  |  |  |                               |
| (c) _____   |   |  |  |  |                               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |   |  |  |  |                               |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                               |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7-11- 1985   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)              |                               |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                               |
|   |   |  |  | 9902-E Tailspin Lane Balto. MD   |                               |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |  |  |                               |
| ACTUAL SIGNATURE  |   | TITLE (SPECIFY)  |  | DATE SIGNED  |                               |
| Ann M. Dixon, M.D.  |   | M.D. Assistant MEDICAL EXAMINER  |  | 7-13-85  |                               |
| EXAMINER'S NAME (TYPE OR PRINT)   |   | ADDRESS  |  |  |                               |
|   |   | 111 Penn St., Balto., MD 21201   |  |  |                               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |                               |
| Burial  | 7/16/85   | Holly Hill Memorial Gardens  |  | Baltimore Co., Md.   |                               |
| 24. FUNERAL DIRECTOR (NAME AND ADDRESS)   |   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |                               |
| Brodzinski Funeral Home PA 1407 Old Eastern Ave   |   | JUL 15 1985  |  | [Signature]  |                               |

9

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 18984

219097

FOR  
1- STATE  
REGISTRAR

|  |  |  |   |   |                    |   |  |  |  |  |  |   |  |   |  |
|--|--|--|---|---|--------------------|---|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Ruth Esther Walther  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>07 31 85 |   | 2b. HOUR<br>7:05pm |   |  |  |  |  |  |   |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 29 13   |                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | 8. IF UNDER 24 HRS<br>HOURS MIN.   |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                  |  |  |  |  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Meridian Nursing Center |   |   |                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |  |  |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Md. Baltimore Catonsville  |  |  |   |   |                    |   |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>412 Bloomsbury Avenue 21220 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown Sayman   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |                    |   |  |  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-64-7037   |   | 17. INFORMANT<br>ADDRESS<br>Andrew G. Walther Jr. Same as #13   |                    |   |  |  |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Recurrent cerebrovascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic hypertension arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>dissect</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |                    |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a  |  |  |   |   |                    |   |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                    |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                    |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> 19 <u>85</u> , to <u>7/31</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7/31</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.  |  |  |   |   |                    |   |  |  |  |  |  |   |  |   |  |
| 27a. SIGNATURE<br><u>Herbert J. Levickas MD</u>  |  |  |   | DEGREE<br>MD  |                    |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 27b. DATE SIGNED<br><u>7/31/85</u>  |  |   |  |
| 27c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Herbert J. Levickas MD</u>   |  |  |   | 27d. ADDRESS<br><u>5404 East Drive (21220)</u>  |                    |   |  |  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  |   | 23b. DATE<br>8-3-85   |                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Lakeview Mem Park                       |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sykesville Md.   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MacNabb Funeral Home   |  |  |   |   |                    | ADDRESS<br>Catonsville Md   |  | 25a. DATE REC'D. BY REGISTRAR<br>AUG 5 1985  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2088 COTTON 6802

11/14/74



700115

152097

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 1 8 9 8 5

|  |  |   |  |  |                            |  |
|--|--|---|--|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EVELYN M WAMPLER</b>            |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 12 1985</b> |  | 2b. HOUR<br><b>6:50 AM</b> |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOV. 13 1911</b>  |                            |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br><b>WASH., D.C.</b>                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>73</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY</b> MD.   |                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SECRETARY - RETIRED</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOVT.</b>  |  |  |                            |  |

|   |                              |   |   |   |  |
|---|------------------------------|---|---|---|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |                              |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 13a. STATE<br><b>MD.</b>  | 13b. COUNTY<br><b>BALTO.</b> | 13c. CITY OR TOWN<br><b>COCKEYSVILLE</b>                                      | 13e. STREET ADDRESS / ZIP CODE<br><b>10028 HILL GREEN CIRCLE APT. G 21030</b>                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM F. BERGER</b>                      |                              |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CORNELIA GENTNER</b>                        |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>       |                              | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>545-40-2132</b> |   | 17. INFORMANT<br>ADDRESS<br><b>FAMILY RECORDS</b> |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Infarction of right cerebral hemisphere</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Thrombosis of rt. middle cerebral artery</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral edema</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Cerebral Edema</b>   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I, this hospital) attended the deceased from <b>6-85</b> , 19 <b>85</b> , to <b>7-12</b> , 19 <b>85</b> , that (we) last saw the deceased alive on <b>7-12</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) move the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Samuel C. H. Lee, M.D.</b>   |  |  |  | 22c. DATE SIGNED<br><b>7/12/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SAMUEL C. H. LEE, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>1620 YORK RD TOWSON MD 21204</b>                                  |  |

|  |  |                                 |  |  |  |
|--|--|---------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b> |  | 23b. DATE<br><b>13 July 85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN MOUNT</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS CHAPEL OF CHIMES</b>    |  | ADDRESS<br><b>2325 YORK RD.</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 15 1985</b>      |  |
|  |  |                                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b> |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified of and

BP



Department of Agriculture  
Washington, D.C.  
Circular 1000

United States

1/12/82

1/12/82  
J. H. Lee, Jr.  
1/12/82



205016

DIVISION OF VITAL RECORDS, 20 W. PRESTON ST., BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued, the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. The burial-transit permit is required for the removal of the body from the place of death to the place of burial or cremation. The burial-transit permit is required for the removal of the body from the place of death to the place of burial or cremation.

IMPORTANT: If item 21 is marked on item 18 shows any injury or other abnormal event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 9 8 6  
REG. NO.

|   |  |  |   |  |                                   |
|---|--|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |                                   |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |   | 8:15p M  |                                   |
| FIRST MIDDLE LAST   |  | July 16, 1985  |   |  |                                   |
| Nancy Harriet Ward  |  |  |   |  |                                   |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR  |                                   |
| FEMALE  | WHITE  | MONTH DAY YEAR   | 75 YRS.   | MONTHS DAYS HOURS MIN.   |                                   |
|   |  | JUNE 11, 1910  |   |  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |
| N.Y.  | USA  |  | Baltimore County MD.  |  |                                   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| ROSEDALE  | FRANKLIN SQUARE HOSPITAL   |  | AIDE  |  | NURSING                           |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  |                                   |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS / ZIP CODE   |                                   |
| MD  | BALTIMORE  | DUNDALK  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 7834 ST. BRIOGET LANE 21222  |                                   |
| 14. FATHER'S NAME (TYPE OR PRINT)   |  | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)   |   |  |                                   |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |   |  |                                   |
| ARTHUR WEST WORTON  |  | VASHTI MAUDE HICKS   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS   |  |                                   |
| NO  |  | 214 38 4153  | EDWARD S. WARD SAME AS #13e   |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |                                   |
| PART I. DEATH WAS CAUSED BY:  |  |  |   |  |                                   |
| IMMEDIATE CAUSE (a) Severe Arteriosclerotic Vascular Disease  |  |  |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |                                   |
| (b) Pulmonary Edema with Large Cell Cancer of Lung  |  |  |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |                                   |
| (c) Bleeding Gastric Ulcer  |  |  |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |   |  |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   |
|   |  |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
|   |  | P.M. 19  |   |  |                                   |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                   |
| INJURY <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |   |  |                                   |
| 22a. I certify that (this hospital) attended the deceased from July 5, 19 85, to July 16, 19 85, that (we) last saw the deceased alive on July 16, 19 85, and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did) (did not) view the body after death. |  |  |   |  |                                   |
| 22b. SIGNATURE  |  | DEGREE   |   | 22c. DATE SIGNED   |                                   |
| [Signature]   |  |  |   | 7-16-1985  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |  |                                   |
| FAILL Adam  |  | 9000 Franklin Square Dr. 21237   |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   |
| BURIAL  |  | 19JULY85   |   | BEL AIR MEMORIAL GARDENS   |                                   |
| 23d. LOCATION (CITY OR TOWN COUNTY STATE)   |  | 23e. DATE REC'D. BY REGISTRAR  |   | 23f. REGISTRAR'S SIGNATURE   |                                   |
| BEL AIR, HARFORD CO., MARYLAND  |  | JUL 19 1985  |   | [Signature]  |                                   |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |
| MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078   |  |  |   |  |                                   |



102016

[The main body of the page contains extremely faint, illegible text, likely bleed-through from the reverse side of the document. The text is organized into several paragraphs and possibly a list or table, but the characters are too light to transcribe accurately.]

207167

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem performed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 18987

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Emma L. Warfield</i>  |  | 20. DATE OF DEATH MONTH DAY YEAR<br><i>July 21, 1985</i>  |  | 2b. HOUR<br><i>4:45 AM</i>  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>Oct. 9, 1908</i>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Pennsylvania</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>76</i> YRS.   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Towson</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Manor Care Towson 21204</i> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County MD</i>                              |  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Balto.</i>  |  | 13c. CITY OR TOWN<br><i>Towson</i>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Abner Garrett Fell</i>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Mary McKinstry Gillingham</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>169-12-0765</i>  |  | 17. INFORMANT ADDRESS<br><i>Mrs. M.A. Nichols 3 Lynfair Ct. 21234</i>                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cancer of the uterus</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. {<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>20 months</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/23</i> 19 <i>85</i> to <i>7/21</i> 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>7/20</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE <i>Walter J. Kees</i> DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  | 22c. DATE SIGNED<br><i>7/21/85</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>WALTER J. KEES</i>   |  |   |  | 22e. ADDRESS<br><i>Monkton, Md 21111</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Cremation</i>  |  | 23b. DATE<br><i>7/22/85</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Greenmount</i>   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Baltimore City Md.</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUL 24 1985</i>   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Mitchell-Wiedefeld Home</i>  |  | ADDRESS<br><i>6500 York Road 21212</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>W. Wiedefeld</i>   |  |

BP

100-100000



210181

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 8 8  
REG. NO.

|   |  |  |  |   |                      |  |  |  |  |  |  |  |  |
|---|--|--|--|---|----------------------|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Stephen M. WARGO Sr.   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 22, 1985 |   | 2b. HOUR<br>7:15P.M. |  |  |  |  |  |  |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 7, 1920  |                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65<br>YRS.                                |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | 8. IF UNDER 24 HRS<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21237  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Sq. Hospital |  |   |                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Finisher |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel   |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  |   |                      | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Essex   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Andrew Wargo  |  |  |  |   |                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susan ?                     |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-   |  | 17. INFORMANT<br>Stephen M. Wargo, Jr. Son  |                      | ADDRESS<br>630 Falconbridge Dr. Joppatown, Md.                               |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>asystole</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>cardiomyopathy</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |                      |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |  |  |   |                      |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                      |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                      |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM, ETC.)   |                      |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-20</u> , 19 <u>75</u> , to <u>7-22</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                     |  |  |  |   |                      |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>John Rumbly MD</u>   |  |  |  |   |                      |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>7-23-85  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   |                      |  |  | 22e. ADDRESS   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br>Burial  |  |  |  | 23b. DATE<br>7/25/85  |                      | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Memorial Pk.               |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Howard Co., Md.  |  |  |  |
| 24. FUNERAL HOME<br>Brudzinski Funeral Home PA 1407   |  |  |  |   |                      |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 25 1985   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |  |  |

MEDICAL CERTIFICATION

219

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TQ FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



159038

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH AND MUST BE FORWARDED TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P-1. BEGIN PAGE 5 FOR YOUR FILES. PAGE 6 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P-2. BEGIN PAGE 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP 1235

DHMH - 17  
(VR AT 15 ME (5))  
15M/7/76

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |   |  |  |  |   |  | REC NO 8989   |  |  |  |                |  |
|---|--|------------------|--|---|--|--|--|---|--|---|--|--|--|----------------|--|
| 1- STATE REGISTRAR  |  |                  |  |   |  |  |  |   |  |   |  |  |  |                |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Victoria T. Warr   |  |                  |  |   |  |  |  |   |  | 20. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>July 11 1985                           |  | 2b. HOUR<br>6A   |  |                |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 8, 1926  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>58 YRS.                          |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>July 11 1985   |  | 2d. HOUR<br>6A |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD. |  |                |  |
| 10. CITY OR TOWN OF DEATH<br>Baldwin  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>13819 Ansari Lane (Residence) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                            |  |                |  |
| 13a. STATE<br>Maryland  |  |                  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baldwin   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>13819 Ansari Lane 21013                                      |  |  |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Silvestri   |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Josephine Cottone       |  |   |  |   |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-22-2586  |  | 17. INFORMANT<br>ADDRESS<br>Robert P. Warr Jr. 3204 Parkside Drive 21214 |  |   |  |   |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE<br><u>Chronic Monoxide Poisoning</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>                       |  |  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |   |  |  |  |   |  |   |  |  |  |                |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 19. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                |  |
| 21a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |  |  |   |  |   |  |  |  |                |  |
| ACTUAL SIGNATURE<br><u>Charles F. Donnell</u>   |  |                  |  | TITLE (SPECIFY)<br><u>Deputy</u>  |  |  |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br><u>7/11/85</u>                                |  |                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |                  |  | ADDRESS   |  |  |  |   |  |   |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Entombment   |  |                  |  | 23b. DATE<br>Jul 13 1985  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery                  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                    |  |  |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc.   |  |                  |  |   |  | ADDRESS<br>Baltimore, Maryland   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 12 1985  |  | 25b. REGISTRAR'S SIGNATURE<br><u>One Warrdon Ruck</u>                               |  |  |  |                |  |



1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000



1000

1000

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

189117

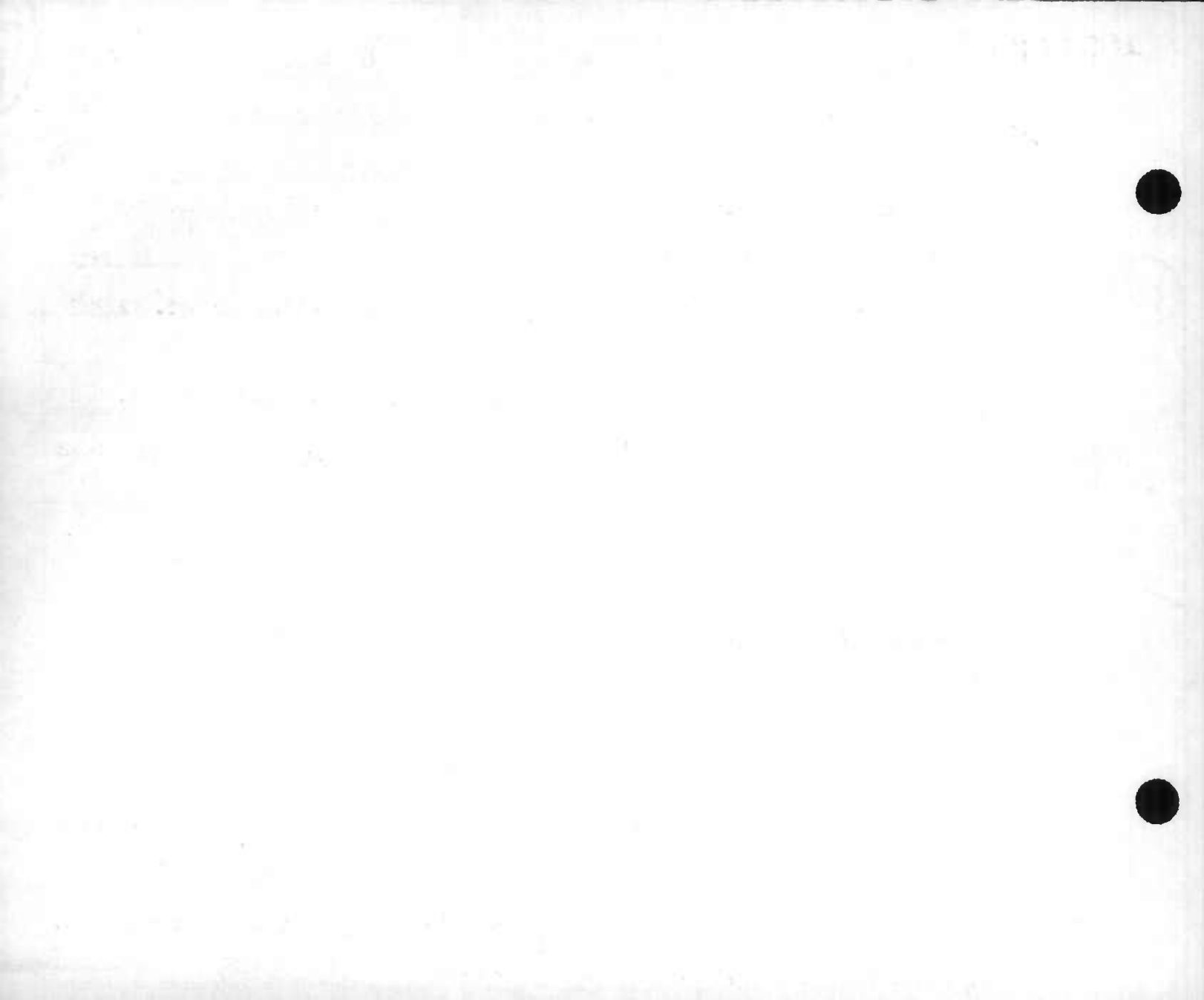
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 1 8 9 9 0

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Orville F. Warren  |  |   | 7a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 2, 1985        |  | 7b. HOUR<br>7:50A <sub>M</sub>   |
| 3. SEX<br>MALE  | 4. RACE<br>White                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 16 28   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |
| 10. CITY OR TOWN OF DEATH<br>Balto. Highlands   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3019 Louisiana Avenue                          |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Proprietor       | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bait Shop   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Baltimore                                   | 13c. CITY OR TOWN<br>Balto. Highlands  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ernett Joseph Warren  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice Lee |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>220-22-7207   |  | 17. INFORMANT<br>ADDRESS<br>Mary K. Warren 3019 Louisiana Ave. 21227                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 mo.  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>11/5/84   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CARCINOMA - LUNG  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on <u>5/15</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.              |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Karl F. Meach Jr.</u>  |  | DEGREE  |  | 22c. DATE SIGNED<br>6/2/85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Karl F. Meach Jr.  |  | 22e. ADDRESS<br>3350 Wilkens Avenue 21229   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>7/5/85                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Lakeview Mem. Pk.,  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sykesville Carroll Md.                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.  |  | 24b. ADDRESS<br>21229<br>4107 Wilkens Avenue  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 03 1985   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  |  |  |

BP



213079

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 9 9 1  
REG. NO.

|  |  |  |   |   |                              |   |  |
|--|--|--|---|---|------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Arthur S. Waugh Jr.</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>July 27, 1985</i> |   | 2b. HOUR<br><i>3:40 P.M.</i> |   |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3-8-1910</i>   |                              | 6. AGE<br>(IN YEARS (LAST BIRTHDAY))<br><i>75</i> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>Balto. City</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Essex</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>329 Stillwater Road- 21221</i> |   |   |                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Steward-Retired</i>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Gardenville</i>  |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Md.</i>                       |   | 13b. COUNTY<br><i>Balto.</i>  |                              | 13c. CITY OR TOWN<br><i>Essex</i>   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><i>Base 329 Stillwater Rd.-21221</i>   |   | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Arthur S. Waugh Sr.</i>  |                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Susie Harvey Keen</i>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes Navy</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><i>30-34 212-10-5970</i>   |   | 17. INFORMANT<br><i>8508 Harris Ave. Mr. Edward F. Waugh Balto. Md.-21234</i>   |                              | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic Renal Cancer</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |  |   |   |                              |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |                              |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                              |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12-19-84</i> to <i>3/1/85</i> , that (I) <i>was</i> <del>was not</del> saw the deceased alive on <i>2/1/85</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>verily</del> <i>did not</i> view the body after death. |  |  |   |   |                              |   |  |
| 22b. SIGNATURE<br><i>Myu</i>   |  | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                              | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MYU THAM</i>   |  | 22e. ADDRESS<br><i>9101 FRANKLIN ST. DR BALTO, MD 21237</i>  |   |   |                              |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>7-30-85</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Moreland Memorial Park</i>   |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto, Md.</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>John C. Miller Inc-6415 Belair Rd.-21206</i>  |  | ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>JUL 29 1985</i>   |                              | 25b. REGISTRAR'S SIGNATURE<br><i>Davidson-Rendall</i>   |  |

MEDICAL CERTIFICATION

541

35

35

35

35

35

35

35

35

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove embossed paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. If item 21 is marked "X", it shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 1 8 9 9 2  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>James M. WEBER  |  |  |  | July 7, 1985  |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Cauc.   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8/27/07  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Purchasing Agt.  |  | 12b. BALTO. BUSINESS OR INDUSTRY<br>Fountain Co.  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY - 13c. CITY OR TOWN Balto.  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>4716 Ellison Ave. 21206   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Henry Weber  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Katherine Roesch  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No -   |  | 16b. SOCIAL SECURITY NO.<br>216-09-1168  |  | 17. INFORMANT ADDRESS<br>Frances Weber, same address  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that X (this hospital) attended the deceased from 7-3, 19 85, to 7-7, 19 85, that X (we) lost the deceased alive on 7-7, 19 85, and that in X (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (do not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Richard Benivegna MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>7-7-85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard Benivegna, M.D.  |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Drive 21237  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>7/10/85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bohemian National   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto. Md.   |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.  |  |  |  | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JUL 09 1985  |  |   |  |
| 3331 Brehms Lane, Balto., Md. 21213   |  |  |  |   |  |   |  |

220000

50% COTTON FIBER

MADE IN U.S.A.



JUL 9 1966

206074

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 1 8 9 9 3

|   |  |   |   |   |  |  |                                   |   |  |
|---|--|---|---|---|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Marie L. WEIDE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 19, 1985</b> |   | 2b. HOUR<br><b>8:03 P<sub>M</sub></b>  |  |                                   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Cauc.</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 5 1905</b>  |  | 6. AGE [IN YEARS (LAST BIRTHDAY)]<br><b>79</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN.         |                                   |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hosp.</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unknown</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                   | 13e. STREET ADDRESS<br><b>120 N. Belnord Ave. 21224</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Welzant Frances Lieski</b>  |   |   |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-20-6157</b>  |   | 17. INFORMANT ADDRESS<br><b>Charlotte Baker 2822 E. Baltimore St</b>  |  |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable pulmonary embolus</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |   |   |  |  |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>a</b>   |  |   |   |   |  |  |                                   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                                   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 30</b> , 19 <b>85</b> , to <b>July 19</b> , 19 <b>85</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 19</b> , 19 <b>85</b> , and that in <del>the</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. |  |   |   |   |  |  |                                   |   |  |
| 22b. SIGNATURE<br><b>Omar Kayaleh, M.D.</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |   |   | 22c. DATE SIGNED<br><b>7/19/85</b>  |  |  |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Omar Kayaleh, MD</b>  |  |   |   | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>7/23/85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>B. Dabrowski &amp; Son 2818 E. Baltimore St.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 22 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Gisela Davidson-Randall</b>   |                                   |   |  |

MEDICAL CERTIFICATION

35  
23  
20  
27

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

200000

1

1

200000

1

200000

20

200000

200000

200000

x

200000

200000

200000

200000

200000

x

200000

200000

200000

200000

200000

200000

200000

200000

200000

200000

200000

200000

200000

200000

200000

200000

200000

200000

200000

200000

200000



211095

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND   |  |  |  |   |  |  |                      |  |  |
|---|--|--|--|---|--|--|----------------------|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |  |                      |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |                      |  |  |
| 85 REG. NO. 18994   |  |  |  |   |  |  |                      |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>GEORGE M. WEINER  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JULY 23, 1985  |  |  | 2b. HOUR<br>5:45P.M. |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 26, 1949   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>36 YRS.   |                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                         |                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7915 CRISFORD PL., APT. F (21208) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ASST.-MANAGER    |                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>PHARMACY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>7915 CRISFORD PL., APT. F (21208)                  |                      |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>DAVID WEINER  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>EVELYN KRAMER  |  |  |                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-50-7236   |  | 17. INFORMANT<br>ADDRESS<br>DAVID WEINER 7915 CRISFORD PL., APT. F (21208)  |  |  |                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |  |                      |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on <u>7/23</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |                      |  |  |
| 22b. SIGNATURE<br><u>Steven A. McAsson</u>  |  |  |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |                      | 22c. DATE SIGNED<br><u>7/23/85</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>STEVEN A. McASSON</u>   |  |  |  | 22e. ADDRESS<br><u>600 Reisterstown Rd.</u>   |  |  |                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>7/25/85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OHEB SHALOM MEM. PARK REISTERSTOWN BALTO. MARYLAND  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE BALTO. MARYLAND              |                      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 26 1985  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                     |                      |  |  |

2004

1

2004 COLLECTION FIBER

204130

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 G. NO. 18995

|   |  |  |  |   |  |   |   |   |  |
|---|--|--|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>SHIRLEY S. WEINSTEIN</b>    |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JULY 10, 1985</b> |   | 2b. HOUR<br><b>4 P M</b>   |   |   |   |  |
| 1. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 9, 1921</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                             |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1314 CHURCH HILL DR. 21208</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b> |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |  |   |  |   |   |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>1314 CHURCH HILL DR. 21208</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BENJAMIN SIEGEL</b>                        |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>GUSSIE DENABURG</b>   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>       |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-03-6955</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MR. JERRY WEINSTEIN 1314 CHURCH HILL DR. 21208</b>               |   |   |  |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Metastatic colon Ca.*

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on <b>2/6</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Steve G. Gasson</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7/14/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEVE GASSON</b>  |  |   |  | 22e. ADDRESS<br><b>600 REISTERSTOWN RD</b>   |  |   |  |

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>       |  | 23b. DATE<br><b>7/12/85</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. HEBREW CEM</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>REISTERSTOWN BALTO. MD</b> |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>SOL LEVINSON &amp; BROS. INC.</b> |  |                             |  | 24. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JUL 16 1985</b> <i>John Davidson-Randall</i> |  |   |  |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215                     |  |                             |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filed in by the funeral director. Page 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

15.2.12

CHARLES W. BROWN

FOX COTTON FIBRE



BROWN

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

159130

| HARRY VOREL   |  | STATE OF MARYLAND  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Harry Vorel  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>7-6-85   |  |
| 3. SEX<br>male  | 4. RACE<br>white   | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 11 09   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>MARYLAND   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Smear Hospital | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |
| 12a. USUAL OCCUPATION<br>WARD OF MD. STATE  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  | 13b. COUNTY<br>BALTIMORE   |  |
| 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 13e. STREET ADDRESS / ZIP CODE<br>2444 Shirley Lane, 21215  |  |  |  |
| 14. FATHER'S NAME<br>JOSEPH MIDDLE<br>VOREL   |  | 15. MOTHER'S MAIDEN NAME<br>AGNES MIDDLE<br>VLK  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>220546032T   |  |
| 17. INFORMANT<br>H<br>A<br>ELsie SCHMIDT  |  | ADDRESS<br>621 LUTHER ST. 21225  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) disseminated urinary sepsis<br>DUE TO, OR AS A CONSEQUENCE OF (b) urease ptosis<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 30, 19 85, to July 6, 19 85, that (I) (we) last saw the deceased alive on July 6, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br>Maurice H. Zisk MD  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22c. DATE SIGNED<br>7-6-85  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>7/9/85  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY REDEEMER   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. --- MD.   |  |
| 24. FUNERAL DIRECTOR'S NAME<br>J. J. H. H.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 08 1985   |  |
| 25b. REGISTRAR'S SIGNATURE<br>J. J. H. H.   |  |  |  |



219016

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 18997

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 20. DATE OF DEATH<br>MONTH DAY YEAR   |  | 2b. HOUR   |  |
|   |  | RAY HOUSTON WELDON   |  | 07 31 '85   |  | 12:35P M   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Apr. 5, 1895  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kansas   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREATER BALTIMORE MEDICAL CENTER  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Manger  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Roto Rooter   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.   |  | 13b. COUNTY<br>BALTO   |  | 13c. CITY OR TOWN<br>Ruxton   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>valandingham Weldon   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mollie Peugh  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW1 510 18 1432   |  |
|   |  | 17. INFORMANT<br>ADDRESS<br>family records   |  |   |  |  |  |
|   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) RUPTURED ABDOMINAL AORTIC<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ANEURYSM<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION<br>7/28/85   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>RUPTURED ANEURYSM  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/28, 1985, to 7/31, 1985, that (I) (we) last saw the deceased alive on 7/31, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>S. Girdhar   |  | 22c. DATE SIGNED<br>7/31/05   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SARVA P. GIRDHAR, M.D.   |  | 22e. ADDRESS<br>GBMC - 6701 N. CHARLES STREET 21204  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>burial   |  | 23b. DATE<br>8/6/85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ionia Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Ionia, Kansas  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Evans Chapel of Chimes  |  | 25a. ADDRESS<br>2325 York Road   |  | 25b. RECEIVED BY REGISTERAR<br>AUG 5 1985   |  | 25c. REGISTERAR'S SIGNATURE  |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



100%

20% COTTON FIBER

100% COTTON FIBER



100%

100%



207163

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 18998

|   |  |   |  |   |  |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Bessie Wikel</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 19, 1985</b>          |   | 2b. HOUR<br><b>8:00a</b> M   |  |  |  |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 30 93</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. County</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Private</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>/62// 6116 Belair Rd. 21206</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                        |   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Unkn.</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>216-32-8430</b>                       |   | 17. INFORMANT ADDRESS<br><b>Ms. Elizabeth Rodney Balto., Md. 5810 Arizona Ave.</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gram negative septic shock</b><br><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
|   |  |   |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                     |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>July 14</b> , 19 <b>85</b> , to <b>July 19</b> , 19 <b>85</b> , that (we) last saw the deceased alive on <b>July 19</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Carlos J. Page</i><br>DEGREE<br><b>M.D.</b>  |  |   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>7/19/85</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carlos Page, M.D.</b>   |  |   |  |   | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>   |  |   | 23b. DATE<br><b>7/19/85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>  |  |   |  |   | ADDRESS<br><b>Balto., Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 24 1985</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Lelia Davidson-Rendell</i>          |  |

BP

COPIES

2



200 COTTON

WHEAT



150054

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 1 8 9 9 9

|  |  |  |   |  |   |  |  |   |  |
|--|--|--|---|--|---|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Anna</b>   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 8th 1985</b>                  |  |   | 2b HOUR<br><b>635</b> A.M.   |  |   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug 8th 1898</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                              |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rosedale</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care Nursing Home</b> |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>            |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  |   |  |  |   |  |
| 13a STATE<br><b>Maryland</b>   |  | 13b COUNTY<br><b>Baltimore</b>   |   | 13c CITY OR TOWN<br><b>Rosedale</b>  |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS / ZIP CODE<br><b>66 Ridge Road / 21237</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |   |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |   | 16b SOCIAL SECURITY NO.<br><b>UNKNOWN</b>  |   | 17 INFORMANT<br>ADDRESS<br><b>Carolyn Lorenz, Baltimore, MD 21201</b>                          |  |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Colon Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Type II Diabetes Mellitus and Hypertension</b>   |  |  |   |  |   |  |  |   |  |
| 19a DATE OF OPERATION<br><b>N/A</b>  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>               |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4/6</b> P.M. <b>19</b> |  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>66 Ridge Rd. Suitland, Maryland</b>     |  |   |  |
| 22a I certify that (I (this hospital) attended the deceased from <b>4/6</b> <b>1985</b> to <b>7/8</b> <b>1985</b> , that (I (we) lost saw the deceased alive on <b>7/4</b> <b>1985</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did (did not) view the body after death.)  |  |  |   |  |   |  |  |   |  |
| 22b SIGNATURE<br><b>Samuel Westrick, MD</b><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |   |  |   | 22c DATE SIGNED<br><b>7/8/85</b>   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b DATE<br><b>July 10, 1985</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland, Maryland</b> |   |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>Richard Rapp, Inc.</b><br>ADDRESS <b>1804 T Street, NW, Washington, DC 20009</b>  |  |  |   |  |   | 25a DATE REC'D. BY REGISTRAR<br><b>JUL 12 1985</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>Frederick Randall</b>   |  |



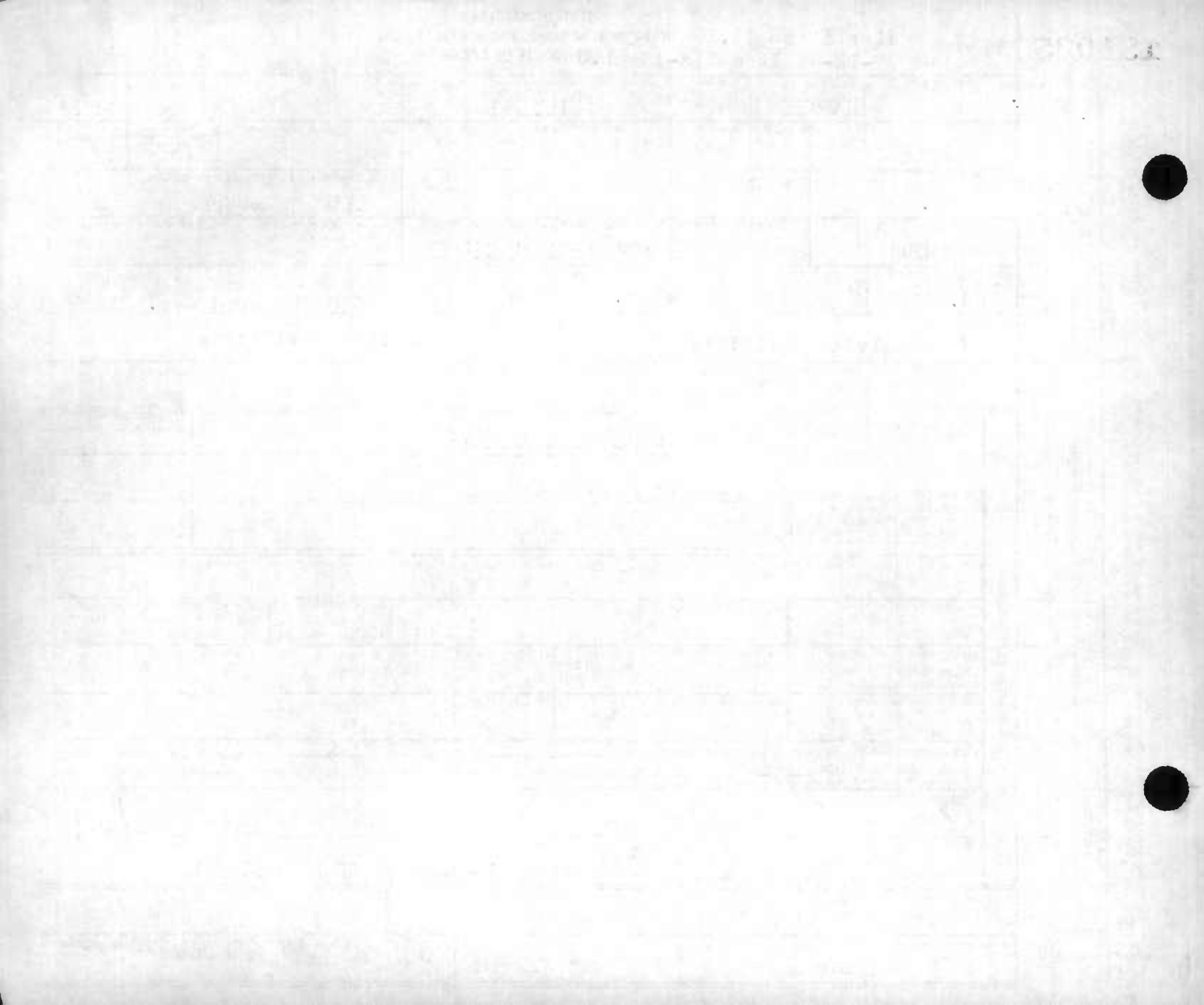


052070

1









212101

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 19002

|   |  |   |   |  |                      |
|---|--|---|---|--|----------------------|
| DECEASED NAME (TYPE OR PRINT)<br>Alfred Mason Winkleman                                 |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>July 26, 1985   |  | 2b. HOUR<br>10:05 AM |
| 3 SEX<br>Male   | 4 RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 9, 1910  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.                             | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                     |  |                      |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21221  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH CITY, GIVE STREET ADDRESS)<br>Franklin Sq. Hospital |   | 12a. USUAL OCCUPATION<br>(IF OF WORK FOR MOST OF WORKING LIFE)<br>Custodian                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. Co. School |                      |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |  |                      |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Essex 21221  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>2 Wilbur Rd. 21221   |                      |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Norman Winkelman                          |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sadie Granger                                  |  |                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>- 212 07 3668  | 17. INFORMANT ADDRESS<br>Lillie V. Aims, Sister Balto., Md. 21226                               |  |                      |

|  |  |   |
|--|--|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Massive Hemorrhage leading to Hypotension<br>and Cardiac Arrest<br>(b) Ruptured Aortic Aneurysm (Abdominal)<br>(c) Atherosclerosis and Hypertension |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Chronic Obstructive Pulmonary Disease  |  |   |

MEDICAL CERTIFICATION

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 26, 1985, to July 26, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 26, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>Satish Khaneja  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>7-26-85   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Satish Khaneja M.D.  |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237  |   |

|   |                      |   |   |
|---|----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br>Burial            | 23b. DATE<br>7/29/85 | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md. |
| 24. FUNERAL DIRECTOR<br>Brodzinski Funeral Home PA 1407 Old Eastern Ave |                      | 25a. DATE REC'D. BY REGISTRAR<br>JUL 29 1985              | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall         |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CONFIDENTIAL



192096

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

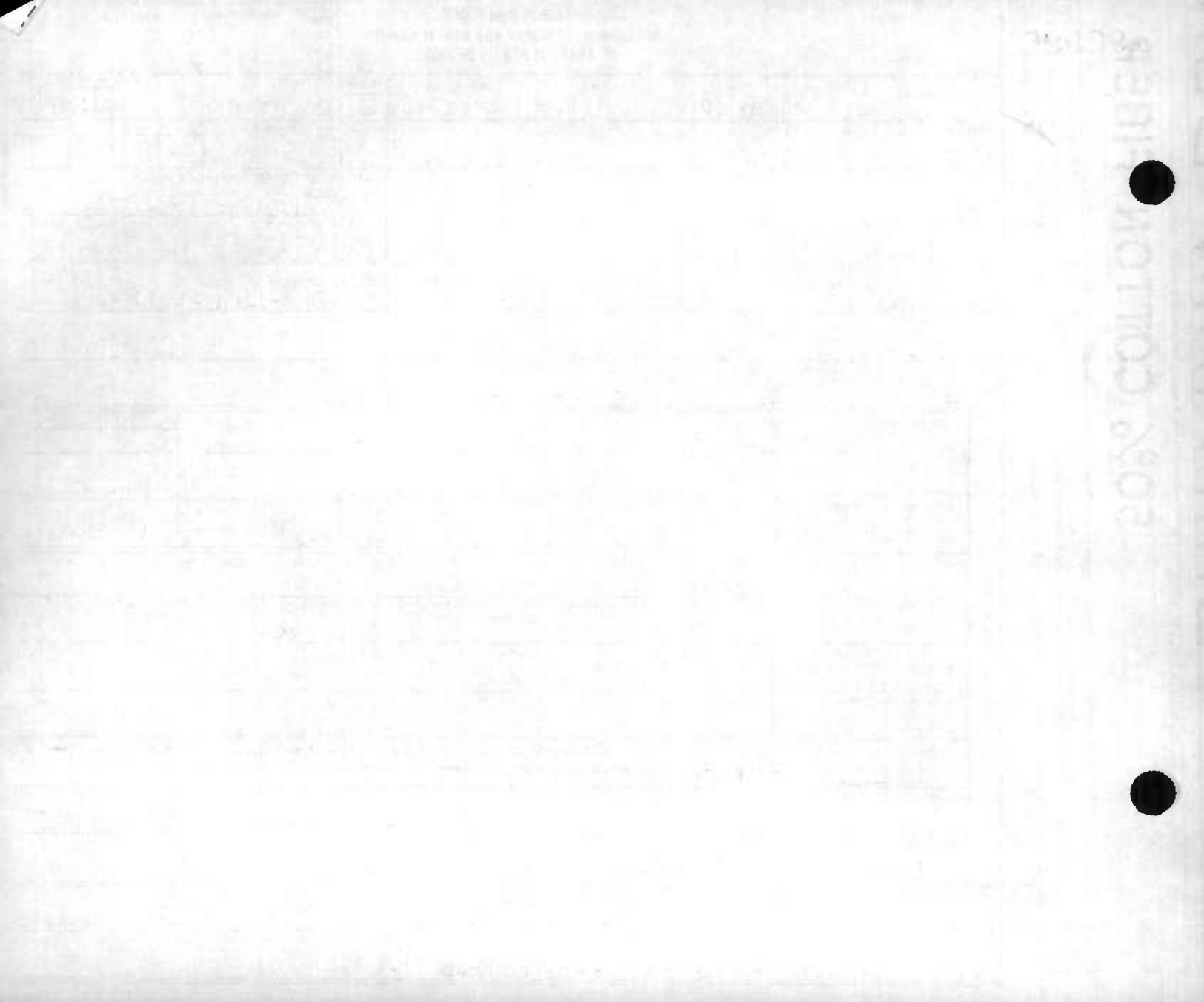
85 REG. NO. 19003

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN HENRY WISEMAN</b>   |  |   | 20. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 10, 1985</b>                                     |  | 2b. HOUR<br>P. <b>4:04</b> M.   |
| 1. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOV. 18, 1914</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                             |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>ROSEDALE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BROKER</b>               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>REAL ESTATE</b>                              |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3207 GLENDALE ROAD 21234</b>                    |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM J. WISEMAN, SR.</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELSI DIVER</b>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W.II 21516 01HA</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>FAMILY RECORDS</b>                                    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Ventricular fibrillation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary artery disease</b>  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>1 month</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Diabetes mellitus</b>  |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 10</b> , 19 <b>81</b> , to <b>July 10</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>July 2</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Carla Wolf Rosenthal</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>JULY 11, 1985</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carla Wolf Rosenthal MD</b>   |  | 22e. ADDRESS<br><b>3400 BRIMMS LANE</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>JULY 12, 1985</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MARYLAND</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS CHAPEL OF MEMORIALS</b>  |  | ADDRESS<br><b>8800 HARFORD ROAD</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 15 1985</b>                                  | 25b. REGISTRAR'S SIGNATURE<br><i>Julian Davidson-Randall</i>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



20% COTTON FIBER

MADE IN U.S.A.

190032

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

85 REG. NO. 19004

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>John</u> <u>WOJECKI</u> |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>7-2-85</u>  |  | 2b. HOUR<br><u>3:55 PM</u>   |  |
| 3. SEX<br><u>Male</u>  |  | 4. RACE<br><u>White</u>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>3-12-1900</u>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><u>(unk)</u>                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>85</u> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |  |
| 10. CITY OR TOWN OF DEATH<br><u>Randallstown</u>                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Baltimore County Hospital</u> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore County</u> MD.  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Butcher</u>     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 13a. STATE<br><u>MD</u>  |  | 13b. COUNTY<br><u>Carroll</u>  |  | 13c. CITY OR TOWN<br><u>Sykesville</u>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>(unk)</u>                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Patricia (unk)</u> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>unk</u> |  | 16b. SOCIAL SECURITY NO.<br><u>21438944A</u>                           |  | 17. INFORMANT<br>ADDRESS<br><u>Central Records, Springfield State Hospital, Sykesville, MD 21784</u> |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST -

DUE TO, OR AS A CONSEQUENCE OF

(b) METASTATIC LUNG DISEASE - RESPIRATORY FAILURE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) LOWER G.I. BLEEDING (COLON CANCER).

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

## MEDICAL CERTIFICATION

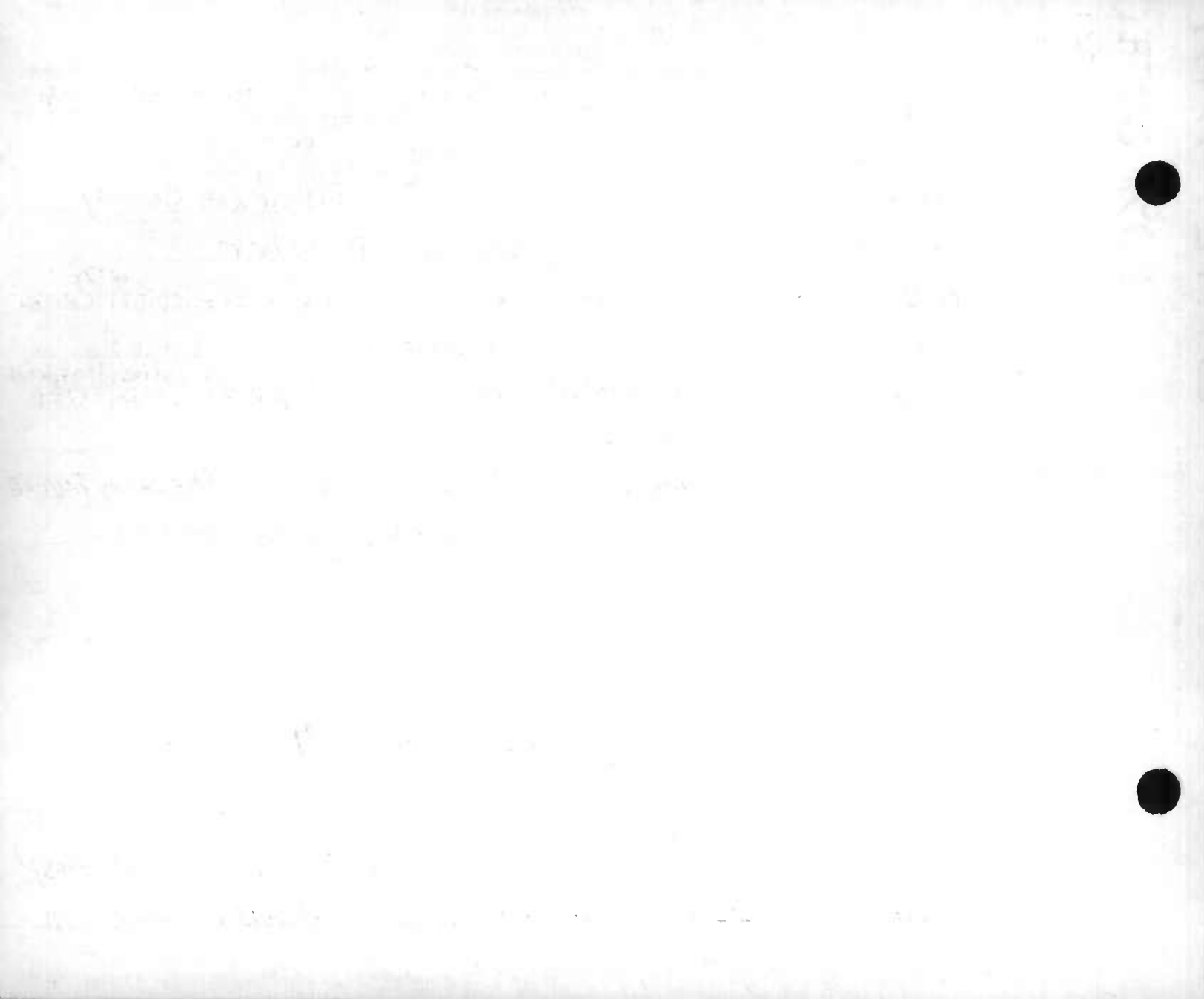
|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-17</u> 19 <u>85</u> , to <u>7-2</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7-2</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  | DEGREE<br><u>MD</u>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>7-2-85</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>R - DEPESTRE</u>   |  | 22e. ADDRESS<br><u>BALTIMORE COUNTY GENERAL HOSP</u>                     |  |  |  |  |  |

|  |  |                                  |  |   |  |  |  |
|--|--|----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u> |  | 23b. DATE<br><u>7-4-85</u>       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Springfield Cemetery</u> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Sykesville Carroll MD</u> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Harry W. Haight</u>     |  | ADDRESS<br><u>Sykesville, MD</u> |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JUL 10 1985</u>               |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



190145

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH85 REG. NO. 9005  
2a. DATE OF DEATH MONTH DAY YEAR 7 2 85 2b. HOUR 3:15 AM

|   |                  |   |  |   |  |
|---|------------------|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Wolf, Stephanie A.</b> |                  | 2a. DATE OF DEATH MONTH DAY YEAR 7 2 85                           |  | 2b. HOUR 3:15 AM  |  |
| 3. SEX <b>F</b>   | 4. RACE <b>W</b> | 5. DATE OF BIRTH MONTH DAY YEAR 11 14 19                          |  | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>                       |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE Co.</b> MD.                   |                  | 10. CITY OR TOWN OF DEATH <b>TOWSON</b>                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>                           |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>  |                  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  | 13a. STREET ADDRESS / ZIP CODE <b>3024 ARIZONA AVE 21231</b>  |  |
| 13a. STATE <b>MARYLAND</b>  |                  | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN TOMASZEWSKI</b>                     |                  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOSEPHINE POLAK</b> |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  |
| 17. INFORMANT ADDRESS <b>STEPHANIE GOLDSMITA 970 RIVERSIDE DR</b>               |                  | 18. SOCIAL SECURITY NO.   |  | 19. DATE OF OPERATION   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardio-Pulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) **Severe Congestive Heart Failure**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE <b>Beatrice P. Dizon, M.D.</b>   | DEGREE <b>M.D.</b>   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED <b>7/2/85</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |

|   |                           |  |  |
|---|---------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (TYPE IF)               | 23b. DATE <b>7-5-1985</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART JESUS</b> | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b> |
| 24. FUNERAL DIRECTOR NAME <b>RAYMOND L. KACZOROWSKI</b> |                           | 25a. DATE REC'D BY REGISTRAR <b>JUL 03 1985</b>              |  |
| 25b. REGISTRAR'S SIGNATURE                              |                           |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



7-2-30

Stephanie

William Co.

U.S.A.

Telegraph

Western

Telegraph

Telegraph

Telegraph

Telegraph

Telegraph

Telegraph

Telegraph

Telegraph

Telegraph

Telegraph

Telegraph

Telegraph

Telegraph

Telegraph



213146

1. FOR  
STATE  
REGISTERSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 1 9 0 0 6

|  |  |   |  |   |  |  |   |  |  |                                    |   |  |
|--|--|---|--|---|--|--|---|--|--|------------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Novis K. F. Woo  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>July 26, 1985                                       |   | 2b. HOUR<br>8:17 <sup>a</sup> M  |  |   |  |  |                                    |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 2 1938   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>46 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |  | IF UNDER 24 HRS<br>HOURS MIN.      |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Hawaii  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |   |  |  |                                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Security Guard   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Globe Security                  |  |                                    |   |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Middle River  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>3521 Dahlia Lane 21220   |                                    |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel F.S. Woo  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mabel Ching                               |   |  |  |   |  |  |                                    |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>576-34-8923  |  | 17. INFORMANT<br>Audrey H.P. Woo  |  |  |   | ADDRESS<br>Same as 13e   |  |                                    |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sudden Heart Attack</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |   |  |  |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Same Day</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |  |   |  |  |                                    |   |  |
| 19a. DATE OF OPERATION<br><u>None</u>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |                                    |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>Residence</u> |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |                                    |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |  |   |  |   |  |  |   |  |  |                                    |   |  |
| 22b. SIGNATURE<br><u>Dean R. Taylor MD</u> DEGREE  |  |   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |  | 22c. DATE SIGNED<br><u>7-26-85</u> |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |   |  | 22e. ADDRESS   |   |  |  |                                    |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>8/9/1985  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge                              |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dorsey Howard Maryland |  |                                    |   |  |
| 24. FUNERAL DIRECTOR<br>(2255.9)<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, Maryland 21222  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 30 1985   |   | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>           |  |                                    |   |  |

1815



THE UNIVERSITY OF CHICAGO  
LIBRARY

221134

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 19007

|  |  |  |   |   |                          |  |
|--|--|--|---|---|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Harry WOODARD</b>                 |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 30, 1985</b> |   | 2b. HOUR<br><b>7:43P</b> |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 12, 1917</b>      |                          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>67</b> |                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> |                          |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Insurance Co.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   | MD.   |                          |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Essex</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Tally M. Woodard</b>    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillie Mae Gwynn</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |  | 16b. SOCIAL SECURITY NO.<br><b>238-14-0346</b>                           |  | 17. INFORMANT<br>ADDRESS<br><b>Ron Woodard 1700 Old Eastern Ave. 21221</b>                      |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>July 12</b> , 19 <b>85</b> , to <b>July 30</b> , 19 <b>85</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>July 30</b> , 19 <b>85</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) see the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>L. Villalobos, MD</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>7-31-85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>                 |  |   |  |  |  |

|  |  |                             |  |  |  |   |  |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>                           |  | 23b. DATE<br><b>7/31/85</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodward Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodward N. Carolina</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Connelly Funeral Home 300 Mace Ave. 21221</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 6 1985</b>             |  |   |  |
|  |  |                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>            |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1815



1815

1815



205102

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 19008

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>ALICE G. WOOLERY  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>07 18 '85                        |  |   | 2b HOUR<br>6:34 AM   |  |  |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>WHITE  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC. 15, 1919   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS                                       |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.                   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>TOWSON  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREATER BALTIMORE MEDICAL CENTER |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEKEEPER |  | 12b KIND OF BUSINESS OR INDUSTRY<br>HOME   |  |
| 13a STATE<br>MARYLAND   |  |  | 13b COUNTY<br>BALTIMORE  |  | 13c CITY OR TOWN<br>TOWSON  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>NOAH WOOLERY   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARION BELL            |  |   | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO         |  |  |  |
| 16b SOCIAL SECURITY NO.<br>219-16-7996  |  |  | 17 INFORMANT<br>WILLIAM BUTTS TOWSON, MARYLAND                         |  |   | 17 ADDRESS<br>21204  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ARRHYTHMIA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CARDIOGENIC SHOCK<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) MASSIVE ANTERIOR MI |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2d   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/13, 1985, to 7/18, 1985, that (I) (we) lost saw the deceased alive on 7/18, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br>Phillip N. Phillips   |  |  |  |  | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br>7/18/85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PHILLIP N. PHILLIPS, M.D.  |  |  |  |  | 22e. ADDRESS<br>GBMC - 6701 N. CHARLES ST. 21204  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |  | 23b. DATE<br>JULY 22, '85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MORELAND MEM. PARK  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CO., MD                                |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>WILLIAM E. JOHNSON   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 19 1985  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |   |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP

00105

POX  
COTTON  
FIBER



1922

1922

190094

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

85 REG. NO. 19009

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Frank G. Wright</b>  |   |  | 2a. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>10</b> YEAR <b>85</b>                                |  | 2b. HOUR<br><b>M</b>   |
| 3 SEX<br><b>Male</b>  | 4 RACE<br><b>White</b>  | 5 DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>19</b> YEAR <b>05</b>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Alabama</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                              |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cockeysville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>604 Knollcrest Pl. #A</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurance</b>  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Cockeysville</b>  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>604#A Knollcrest Pl. 21030</b>  |
| 14 FATHER'S NAME<br>FIRST <b>Edwin</b> MIDDLE <b>-</b> LAST <b>Wright</b>   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>-</b> MIDDLE <b>-</b> LAST <b>Manning</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>216-10-8389</b>   |   | 17 INFORMANT <b>21030</b> ADDRESS <b>Cockeysville,</b><br><b>Mrs. Marnie Wright 604#A Knollcrest</b>           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic bladder cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>months</u>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Coronary artery disease diabetes</u>   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased die on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did not view the body after death.                                      |   |  |   |  |  |
| 22b. SIGNATURE<br><i>Nathan Rosenblum</i><br>DEGREE <b>MD</b>   |   |  |   | 22c. DATE SIGNED<br><b>7-12-85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Nathan Rosenblum, M.D.</b>  |   |  |   | 22e. ADDRESS<br><b>Suite 105<br/>7600 Osler Drive, Towson 21204</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>7-13-85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cen. Timonium Balto. Md.</b>                           |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Byran W. Clary</b> ADDRESS <b>10 W. Padonia Rd. 21093</b>   |   |  |   | 25a. DATE REC'D. BY REGISTRAR <b>JUL 15 1985</b> 25b. REGISTRAR'S SIGNATURE<br><i>Johanna Davidson-Randall</i> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_





206119

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 19010

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |   |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |  | JULY 19, 1985 12:40pm   |   |
| FIRST MIDDLE LAST   |  |  |  |   |   |
| DAW N. YIN  |  |  |  |   |   |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)  | IF UNDER 1 YEAR   |   |
| FEMALE  | ORIENTAL   | MONTH DAY YEAR   | 92 Yrs.  | MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |
| BURMA   |  | BURMA  |  | COUNTY MD.  |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| TIMONIUM  | 19, DEEPPDALE Dr. TIMONIUM Md. 21093   |  | HOUSEWIFE  | N/A   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |
| MD  |  | Balt.  | TIMONIUM   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           | 19 DEEPPDALE Dr. TIMONIUM Md. 21093                                 |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  |   |   |
| THET S. SHAY  |  | DWINT S. WIN   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |   |
| NO  |  | None   |  | MEHM THAUNG 19 DEEPPDALE Dr. TIMONIUM   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST  |  |  |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF (b) COR PULMONALE  |  |  |  |   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE  |  |  |  |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: OSTEOPOROSIS  |  |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |
| N/A   |  | N/A  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |
|   |  | P.M. 19  |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |   |
|   |  |  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 14, 1984, to Jul. 19, 1985, that (I) (we) lost saw the deceased olive on Jul. 19, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |  |  |   |   |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |   |
| K. S. Dharmasena M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | Jul. 19, 1985   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |   |
| K.S. DHARMASENA, M.D.   |  | 8th, Sixteenth Avenue, Balt. Md. 21225   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION CITY OR TOWN COUNTY STATE                                       |   |
| Cremation   |  | 20 JUL 85  | Westview Crematory   | Catonsville, Maryland   |   |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |   |
| J. E. Lowell Lemmon Padonia & York Rds.   |  | Jul. 22 1985   |  | S. A. Davidson-Randall  |   |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified in writing.

011300

203474

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH85 REG. NO. 1901  
20. DATE OF DEATH MONTH DAY YEAR 07 11 85  
21. HOUR 9:40 P.M.1. DECEASED NAME FIRST MIDDLE LAST  
✓ Clara L. Yingling  
3. SEX Female  
4. RACE White  
5. DATE OF BIRTH MONTH DAY YEAR Feb. 9 1904  
6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.  
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  
7b. CITIZEN OF WHAT COUNTRY? U.S.A.  
8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐  
9. BALTIMORE CITY OR COUNTY OF DEATH  
✓ Baltimore County MD.  
10. CITY OR TOWN OF DEATH  
✓ Catonsville  
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
✓ Meridian Catonsville  
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker  
12b. KIND OF BUSINESS OR INDUSTRYUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE Maryland  
13b. COUNTY Baltimore  
13c. CITY OR TOWN Catonsville  
13d. INSIDE CITY LIMITS? YES ☐ NO ☒  
13e. STREET ADDRESS / ZIP CODE 302 Bloomsbury Avenue 2122814. FATHER'S NAME FIRST MIDDLE LAST Winfield Warfield  
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Grover16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR (UNKNOWN)) No  
(IF YES, GIVE WAR OR DATES)  
16b. SOCIAL SECURITY NO. 215-05-8987  
17. INFORMANT ADDRESS Mary L. Zietler 302 Bloomsbury Avenue 2122818. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Respiratory Failure.  
DUE TO, OR AS A CONSEQUENCE OF (b) Bulbar Stroke 6 wks  
DUE TO, OR AS A CONSEQUENCE OF (c) Other chronic Cardiac Vascular 10 yrs  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

MEDICAL CERTIFICATION  
19a. DATE OF OPERATION  
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
20a. AUTOPSY? YES ☐ NO ☐  
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK  
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from July 11, 1985, to July 11, 1985, that (I) (we) lost saw the deceased alive on July 11, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.

22b. SIGNATURE  
Dr. Nelson McKay MD  
DEGREE  
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐  
22c. DATE SIGNED July 12, 198522d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. McKay  
22e. ADDRESS 1132 N. Rolling Road Balt., MD 2122823a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  
23b. DATE July 15, 1985  
23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park  
23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Maryland24. FUNERAL DIRECTOR NAME ADDRESS 21229  
Hubbard Funeral Home, Inc. 4107 Wilkens Avenue  
25a. DATE REC'D. BY REGISTRAR JUL 16 1985  
25b. REGISTRAR'S SIGNATURE

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1900

APR 28 11 10

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

159122

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 REG. NO. 1 9 0 2

|   |  |   |   |   |                                      |   |   |  |  |  |
|---|--|---|---|---|--------------------------------------|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HARRY E YOST</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>07 04 85</b>                |   |                                      | 2b. HOUR<br><b>8:15 AM</b>  |   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 13, 1911</b>  |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b>  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD                      |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 N. CHARLES ST</b> |   |   |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Self Employed</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Trucking</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>                                       |   | 13c. CITY OR TOWN<br><b>Glen Arm</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>13109 Manor Road, 21057</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Yost</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Albina Lorenz</b> |   |                                      |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br><b>216-30-1299</b>  |   | 17. INFORMANT ADDRESS<br><b>Evelyn E. Yost, same as #13e</b>  |                                      |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PLEURAL EFFUSION</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC LUNG CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 1/2 YEARS</b>  |  |   |   |   |                                      |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 DAYS</b>  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>  |  |   |   |   |                                      |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                      |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>06/24 85 07/04 85</b>   |                                      |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>07/04 85</b> to <b>07/04 85</b> , that (I) (we) last saw the deceased alive on <b>07/04 85</b> , and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |                                      |   |   |  |  |  |
| 22b. SIGNATURE<br><b>H Clark MD</b>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                      |   |   | 22c. DATE SIGNED<br><b>7/04/85</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAL CLARK M. D.</b>   |  |   |   | 22e. ADDRESS<br><b>GBMC 6701 N. CHARLES ST TOWSON</b>   |                                      |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>7-5-85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Park</b>   |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 07 1985</b>   |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                             |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

CONTROL

WITNES

TEST

WITNES

TO BE HUNG IN THE COURT

WITNES

WITNES

WITNES

WITNES

WITNES

WITNES

WITNES

WITNES

WITNES

WITNES

WITNES

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |   |  |  |  |
|--|--|---|--|--|---|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  |   |  |  | 85 REG. NO. 19013   |   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>HELEN I. ZABEN  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>07 31 '85   |   |  | 2b. HOUR<br>8:47A M                          |  |
| 3. SEX<br>FEMALE   |  | 4 RACE<br>WHITE   |  | 5 DATE OF BIRTH<br>DEC. 13, 1936   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.                  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREATER BALTIMORE MEDICAL CENTER |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE   |  |   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>4793 BYRON RD. #21208  |  |  |
| 14 FATHER'S NAME (FIRST MIDDLE LAST)<br>WILLIAM KARMOL   |  |   |  |  | 15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)<br>FLORA WISEMAN                                    |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, GIVE SERVICE (OR UNKNOWN))<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-32-9502  |  | 17 INFORMANT ADDRESS<br>MR. MARTIN ZABEN 4793 BYRON RD. #21208   |   |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) BREAST CANCER WITH ABDOMINAL CARCINOMATOSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/27, 1985 to 7/31, 1985, that (I) (we) last saw the deceased alive on 7/31, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br>David I. Safferman   |  |   |  | DEGREE<br>M.D.   |   |   |  | 22c. DATE SIGNED                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID I. SAFFERMAN, M.D.  |  |   |  | 22e. ADDRESS<br>GBMC - 6701 N. CHARLES ST 21204  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>8-1-85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MIKRO KODESH BETH ISRAEL   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD                    |  |  |  |
| 24 FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>NAME ADDRESS<br>6010 REISTERSTOWN RD., BALTO., MD 21215  |  |   |  | 25a. DATE REG'D. BY REGISTRAR 8/5/85<br>25b. REGISTRAR'S SIGNATURE   |   |   |  |  |  |





FOX COTTON FIBER



210182

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 REG. NO. 19014

1 - FOR  
STATE  
REGISTRAR

Jerry Zahradka

1. DECEASED NAME  
(TYPE OR PRINT)

JERRY

MIDDLE

Zahradka

LAST

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

7-22-85 6:30 P.M.

3 SEX

MALE

4 RACE

WHITE

5. DATE OF BIRTH

MONTH

DAY

YEAR

04 22 09

6 AGE (IN YEARS LAST BIRTHDAY)

76 YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a BIRTHPLACE  
(STATE OR FOREIGN  
COUNTRY)

MD

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

9 BALTIMORE CITY OR COUNTY OF DEATH

BALTO Co.

MD.

10. CITY OR TOWN OF DEATH

Towson

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

St Joseph's Hosp

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Seaman

12b. KIND OF BUSINESS OR  
INDUSTRY

Merchant

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Essex

13d. INSIDE CITY LIMITS?

YES

NO

13e. STREET ADDRESS / ZIP CODE

31 Bladen Rd. 21221

14. FATHER'S NAME

FIRST

Joseph

MIDDLE

Zahradka

LAST

15. MOTHER'S MAIDEN NAME

Bessie

Steckel

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

212 03 8353

17. INFORMANT

ADDRESS

Tillie L. Zahradka, Wife

Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Renal Failure - Uremic

DUE TO, OR AS A CONSEQUENCE OF

a) Carcinoma of bladder

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES

NO

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?

YES

NO

21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 7/14, 1985, to 7/22, 1985, that (I) (we) last saw the deceased alive on 7/22, 1985, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If yes) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ATTENDING  
PHYSICIANMEDICAL  
DIRECTORSTAFF  
PHYSICIAN

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

7/26/85

23c. NAME OF CEMETERY OR CREMATORY

Holly Hill Memorial Gardens

23d. LOCATION

Baltimore Co., Md.

24. FUNERAL DIRECTOR

Brazzinski Funeral Home 1407 Old Eastern Ave

25a. DATE REC'D. BY REGISTRAR

JUL 25 1985

25b. REGISTRAR'S SIGNATURE

John Davidson-Randall

